Appendices

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Appendix A

Department of Veterans Affairs **VHA DIRECTIVE 2000-034**
Veterans Health Administration
Washington, DC 20420 **October 2, 2000**

VHA MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)

1. PURPOSE: This Veterans Health Administration (VHA) Directive describes a new initiative in mental health intensive case management (MHICM) for seriously mentally ill veterans. ***NOTE:*** *This initiative takes the place of existing Intensive Psychiatric Community Care (IPCC) programs, Intensive Community Case Management (ICCM) programs, as well as other similar assertive community treatment (ACT) programs within VHA.*

2. BACKGROUND

a. Severe mental illness, primarily psychoses, is a major problem among veterans. Fiscal Year (FY) 1998 Compensation and Pension (C&P) data indicate that 136,362 veterans are service-connected for psychoses of which over 67,700 use VHA services. Over 174,030 veterans with psychoses, overall, used VHA services in FY 1998. The clinical literature suggests that approximately 20 percent of severely mentally ill patients are in need of intensive community case management services in the typical public mental health system. This intensive multidisciplinary team approach to ambulatory management and treatment of patients in, and coordinated with the community and its services, is clearly distinguished from usual case management by: engagement in community settings of highly dysfunctional patients traditionally managed in hospitals; an unusually high staff to patient ratio; multiple visits per week if needed; interventions primarily in the community rather than in office settings; and fixed team responsibility, around the clock, for total patient care over a prolonged period (see subpar. 2e(2)). Multiple studies, including three recent VHA studies, have shown that the intervention is cost effective, particularly where the service is offered to chronically ill, hospitalized patients and where the model is rigorously adhered to with respect to assertiveness of the intervention and maintaining low caseloads (see sub par. 2d). There is compelling evidence for the effectiveness of ACT in patients with psychosis, but its use may also be considered in severe and persistent affective disorder, post-traumatic stress disorder (PTSD), etc., where independent functioning is impaired. A FY 1998 survey by the Committee on Care of Severely Chronically Mentally Ill (SCMI) Veterans revealed that just over 8,000 veterans currently received some form of mental health team case management from VHA, and of those, only 2,000 met ACT Fidelity Measures criteria for intensive case management. Therefore, a gap in these state-of-the-art services is evident, resulting in unnecessary costs and patient morbidity to VHA.

b. On March 25, 1999, in order to obtain a wider range of views in formulating a VHA-wide approach, the Chief Network Officer appointed a SCMI Strategic Implementation Committee composed of four Clinical Managers, a medical center Director, a Mental Health Care Line Director, the National Director of the Northeast Program Evaluation Center (NEPEC), a representative of Vietnam Veterans Association, and a representative of the Mental Health Strategic Healthcare Group.

THIS VHA DIRECTIVE EXPIRES OCTOBER 31, 2005

c. The SCMI Strategic Implementation Committee considered various models of intensive case management within the Mental Health service area, then defined intensive case management for the severely mentally ill in VHA and the accountability expected from this designated program.

d. MHICM is a cost effective intervention given appropriate case selection. This may seem like a paradox given the known resource intensity of the interventions. The efficiency (offset) results from avoidance of other costly interventions such as multiple or lengthy hospitalizations, and extensive ambulatory clinic use, including visits to emergency rooms. Paragraph 3 notes that these programs need to be established from existing funds. To realize the efficiency and accomplish this out of existent resources requires a shift of resources that previously supported the extensive inpatient and outpatient use to underwrite MHICM. It is acknowledged that there will be a need for expedited mental health resource shifts, as well as shifts from other programs that gain economies from implementation of MHICM, including bed closures, where justified, as this more effective alternative of MHICM is implemented.

e. **Definitions**

(1) **Target Population.** MHICM programs are intended to provide necessary treatment and support for veterans who meet all of the following five criteria:

(a) Diagnosis of Severe and Persistent Mental Illness. Diagnosis of severe and persistent mental illness includes, but is not limited to: schizophrenia, bipolar disorder, major affective disorder, or severe post-traumatic stress disorder;

(b) Severe Functional Impairment. Severe functional impairment is such that the veteran is neither currently capable of successful and stable self-maintenance in a community living situation nor able to participate in necessary treatments without intensive support;

(c) Inadequately Served. This means inadequately served by conventional clinic-based outpatient treatment or day treatment;

(d) High Hospital Use. High hospital use as evidenced by over 30 days of psychiatric hospital care during the previous year or three or more episodes of psychiatric hospitalization;

(e) Clinically Appropriate for MHICM Approach. Patients who are more appropriately managed clinically as inpatients need to remain in the inpatient setting; that is, the positive aspects of MHICM should not be used to justify moving patients who would be better served by inpatient care to this ambulatory care model.

(2) **Description of the Program.** MHICM programs are delivered by an integrated, multidisciplinary team and are based on the Substance Abuse Mental Health Services Administration (SAMHSA) ACT standards. There are four core treatment elements:

(a) Very Frequent Contacts between Care Givers and Patients. The treatment process would include two phases:

1. High intensity of care primarily through home and community visits, with low caseloads (seven to fifteen veterans per clinician), allowing rapid attention to crisis and development of community living skills to prevent crisis in this exceptionally vulnerable population.

2. Appropriate transition to lower intensity care. After 1 year of MHICM treatment, patients can be transferred to either standard care or to continuous treatment by the MHICM team at a lower level of intensity (e.g., with caseloads of up to 30 per clinician). Characteristics of the readiness for a lower level of care would include the following: patients are clinically stable, not abusing addictive substances, not relying on extensive inpatient or emergency services, capable of maintaining themselves in a community living situation, and independently participating in necessary treatments. ***NOTE:*** *NEPEC will monitor this transition through periodic clinical progress reports and will report both levels of intensity separately.*

(b) Flexibility and Community Orientation. Flexibility and community orientation with most services provided in community settings and involving integration with natural support systems whenever possible (e.g., family members, landlords, employer).

(c) Focus on Rehabilitation. Focus on rehabilitation through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care and independent living where possible.

(d) Responsibility. Identification of the team as a "fixed point of clinical responsibility" providing continuity of care for each veteran, wherever the veteran happens to be, for a prolonged period. This is expected to initially be 1 year, but subsequently will be based on a periodic review of continuing need for intensive services.

(3) **Data Recording**

(a) Attachment A-A. Attachment A-A contains the definitions of the revised Decision Support System (DSS) Identifiers for the MHICM workload (546 and 552) as well as the new code for general (non-intensive) mental health case management (564).

(b) Attachment A-B. Attachment A-B provides Veterans Integrated Service Networks (VISNs) and Department of Veterans Affairs (VA) leadership with population-based data to help facilitate assessment of the need for MHICM teams in each VISN. These data include the number of:

1. Veterans who meet inpatient utilization criteria (30 days of psychiatric hospitalization or three admissions);

2. Outpatients who meet diagnostic criteria for schizophrenia, bipolar, or major affective disorder and had six or more mental health outpatient contacts in FY 1998;

3. Veterans in the Psychiatric Special Care category under the Veterans Equitable Resource Allocation (VERA) system, and

4. Psychiatric patients with lengths of stay over 1 year.

(c) After a period during which new teams will be added to the roster of MHICM teams participating in the national program, NEPEC will present a data summary for each VISN of the ratio of MHICM-treated patients to those potentially eligible as estimated by each of the indicators of population need identified in Appendix B. VISNs may use these data to identify potential service gaps.

3. POLICY: It is VHA policy to support the development of case management approaches sufficient to meet the need where appropriate. Where the need for intensive mental health case management is demonstrated, MHICM programs need to be established out of existing funds (see subpar. 2d). ***NOTE:*** *NEPEC, which has developed and evaluated this type of program for 10 years, is providing the leadership for training and monitoring of new and established teams.*

4. ACTION

a. **Facility Actions.** Facilities are to:

(1) Utilize national DSS identifiers to designate MHICM activity.

(2) Provide complete nationally-adopted monitoring information for MHICM in a timely manner.

(3) Maintain team fidelity to the operating principles as described in the program description (see subpar. 2e(2)) and adhere to evidence-based clinical procedures. Adequate resources are needed to provide a critical mass of staff to comprehensively address the needs of these exceptionally vulnerable patients, even in the face of staff turnover and other absences. ***NOTE:*** *At least four clinical Full-time Employee Equivalent (FTEE) are needed for each MHICM team. Additional team members may be required in circumstances where the team is isolated from a VA medical center that can provide 24-hour coverage and emergency services. At sites where there are insufficient patients to justify a full team, consideration is to be given to partnering with the community, e.g., existing ACT teams.*

b. **Monitoring and Training Actions.** Because MHICM is resource intensive and the participating veterans are vulnerable, the following monitoring procedures will be implemented under the leadership of NEPEC. ***NOTE:*** *Forms may be obtained by contacting NEPEC by e-mail at "Robert.Rosenheck@med.VA.gov" or telephone at (203) 937-3850.*

(1) **Standard Intake Data Form (IDF).** Standard IDF will be administered to all new admissions to MHICM. It will document adherence to the eligibility criteria listed above and record baseline data on clinical status, functional impairment, and satisfaction with services. The IDF takes about 30 to 45 minutes to complete per patient.

(2) **Follow-up Data Form (FDF).** Follow-up FDF must be administered 6 months and 1 year after program entry and annually thereafter. It consists of a subset of health status and community adjustment measures from IDF. The FDF takes about 25 to 30 minutes to complete per patient.

(3) **A Clinical Process Form (CPF).** A CPF will document delivery of MHICM service elements and will be completed by each client's primary case manager every 6 months after program entry. The CPF takes about 15 minutes to complete on each patient.

(4) **MHICM Check List and ACT Fidelity Measure.** The MHICM Check List and ACT Fidelity Measure is to be completed by the program director once a year for the entire program. This form takes about 20 minutes to complete.

(5) **VHA Administrative Data**. VHA administrative data will be used to track MHICM process and outcomes using inpatient and outpatient service utilization data available from the Patient Treatment File and the Outpatient Care File in the Austin Data Processing Center.

c. **Mental Health Strategic Healthcare Group (MHSHG) Actions**. The MHSHG will:

(1) Assess, deploy, evaluate, and disseminate quality and cost efficient best practices by utilizing NEPEC, Management Science, and Allocation Resource Center data and expertise.

(2) Oversee effectiveness of MHICM program, monitoring, training, and evaluation by convening a broad based panel of experts to assess clinical and deployment outcomes and to determine future actions.

(a) The expert panel will consist of a NEPEC-based Chair (non-voting), five field members including a Chief Financial Officer (CFO), and three NEPEC and/or VHA Headquarters members. The panel will meet as needed but at least quarterly.

(b) The expert panel will provide a regular biannual summary report of its findings, conclusions and recommendations to the Policy Board.

(c) The expert panel will be responsible for preparing an annual cost and benefit analysis for the Policy Board.

(d) The expert panel will oversee, account, and provide a progress report to the Policy Board at appropriate times, but no less than annually, on the shift of resources to offset the resource needs of the MHICM program.

d. **NEPEC Actions.** NEPEC will:

(1) Provide direct oversight to all MHICM programs to ensure that standards are met through periodic site visits to treatment teams, regular national meetings of team leaders, conference calls, consultation, and national training programs. Programs systematically not meeting standards may be decertified from using the MHICM DSS Identifiers.

(2) Make additional efforts to integrate this data collection into standard VA computerized data systems, to provide sites with spreadsheet summaries of national and site-by-site program results on a regular basis, and to provide clinicians with client-specific output for clinical review.

(3) Be responsible for:

(a) Producing periodic reports on the structure, process, and outcomes of MHICM services for training programs in evaluation and clinical procedures.

(b) Working with the expert panel and its CFO (see subpar. 4c(2)) in the development of an effective costing system, such as activity-based costing, to account the MHICM program.

(c) Facilitating ongoing communication and linkage among programs across the country.

(d) Generating reports on VISN-level population-based needs assessments.

(e) Informing VISN and VA facility-level leadership where standards are problematic and recommending actions to strengthen the MHICM teams.

e. **Network Action**. Each Network will be responsible for:

(1) Addressing population-based needs for MHICM services;

(2) Establishing strategies to provide their severely mentally ill veterans within the described target population (see subpar. 2e(1)) access to MHICM services sufficient to meet the need, and

(3) Supporting recommendations by NEPEC to maintain MHICM standards.

5. REFERENCES: VHA Program Guide 1103.3, June 3, 1999, pages 9-11, 47. ***NOTE:*** *See <http://vaww.mentalhealth.med.va.gov/MHICMRef.htm> on VHA intranet for current clinical references.*

6. FOLLOW-UP RESPONSIBILITY: The Chief Consultant, Mental Health Strategic Healthcare Group (116) is responsible for the contents of this Directive.

7. RESCISIONS. None. This VHA Directive expires the last working day of September 2005.

Thomas L.Garthwaite, M.D.
Under Secretary for Health

Attachments

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ATTACHMENT A-A: DSS IDENTIFIERS (STOPCODE) FOR FISCAL YEAR 2003

(Abstracted from VHA Directive 2003-090) (Note these are updated from the original Directive appendix)

Name/ Description	Stop code	CDR Account	Effective Date	Definition
TELEPHONE/MHICM	546	2780.00	10/1/99	Records patient consultation or psychiatric care, management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the special MHICM teams (see DSS Identifier 552). Includes administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 require that records which reveal the identity, prognosis, diagnosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, are strictly confidential and may not be released or discussed unless there is written consent from the individual.
MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)	552	5117.00	10/1/99	Only VA medical centers approved to participate in MHICM (previously IPCC) programs monitored by NEPEC may use this code. This records visits with patients and/or their families or caregivers by MHICM staff at all locations including VA outpatient or MHICM satellite clinics, MHICM storefronts, MHICM offices, or home visits. Includes clinical and administrative services provided to MHICM patients by MHICM staff. Additional stop codes may not be taken for the same workload.
GENERAL TEAM CASE MANAGEMENT	564	2311.00	10/1/99	Records visits with patients and/or their families or caregivers by members of a case management team performing mental health community case management at all locations. Includes administrative and clinical services provided to patients by team members. NOT to be used for visits by MHICM teams (see DSS Identifier 552) or for case management by individuals who use other stop codes.
MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM) GROUP	567	2314.00	10/1/02	Only VA medical centers approved to participate in MHICM (previously IPCC) programs monitored by NEPEC may use this code. This records group visits with patients and/or their families or caregivers by MHICM staff at all locations including VA outpatient or MHICM satellite clinics, MHICM storefronts, MHICM offices, or home visits. Includes clinical and administrative services provided to MHICM patients by MHICM staff. Additional stop codes may not be taken for the same workload.

ATTACHMENT A-B: MHICM TREATMENT POPULATION ESTIMATE FOR PLANNING PURPOSES

Note: This is the original table from the Directive appendix

	Population Statistics			Discharged Psychiatric Inpatients (1)			Seriously Mentally Ill MH Outpatients			Psychiatric Complex VERA Class Patients (CMI)				Long-Term Inpatients (>1 yr LOS)		
VISN	Total Veterans	Eligible for VA Services	SC for MH Problem	Total Psychiatric Inpatients (1)	Percent Inpatients Eligible for MHICM (2)	Number Inpatients Eligible for MHICM (2)	Total SMI Out-patients (3)	Percent Out Pt's with 6 OP MH Visits (4)	Number Out Pt's with 6 OP MH Visits (4)	Schizophrenia and Dementia	Other Psycho-sis	PTSD	Total	Bed Psych.	Sections Med/ Surg	Total
1	1,500,892	358,094	32,435	5,204	30.9%	1,606	14,489	56.7%	8,220	926	324	435	1,685	94	20	114
2	697,421	194,415	12,296	2,355	41.8%	985	6,699	59.1%	3,961	440	171	200	811	18	0	18
3	1,595,593	335,211	29,644	4,716	45.9%	2,166	13,823	60.4%	8,348	1,250	377	505	2,132	196	23	219
4	1,819,870	497,402	27,526	5,047	35.7%	1,801	14,315	53.5%	7,660	930	295	465	1,690	51	9	60
5	857,564	168,218	9,715	3,405	29.3%	998	7,521	57.3%	4,310	502	112	365	979	62	13	75
6	1,251,189	360,885	22,017	4,936	30.1%	1,487	8,955	44.9%	4,023	501	149	319	969	64	1	65
7	1,367,528	399,439	25,458	4,888	29.1%	1,422	13,664	51.0%	6,967	790	175	569	1,534	67	43	110
8	1,634,357	482,839	43,852	5,083	18.3%	931	22,052	43.8%	9,658	440	247	506	1,193	0	0	0
9	1,060,416	367,654	21,666	4,246	21.9%	931	10,626	42.2%	4,481	391	136	169	696	65	0	65
10	1,151,473	318,983	16,861	3,993	32.9%	1,314	9,416	60.4%	5,691	720	196	372	1,288	4	0	4
11	1,651,186	427,356	18,906	4,240	24.2%	1,025	10,279	44.1%	4,528	849	188	284	1,321	193	25	218
12	1,362,314	319,235	15,530	4,372	39.8%	1,739	10,012	57.7%	5,773	606	368	410	1,384	70	0	70
13	707,005	210,110	11,153	2,533	40.9%	1,036	6,890	63.1%	4,346	317	173	190	680	1	0	1
14	516,075	153,798	6,675	1,711	41.2%	705	3,826	45.3%	1,732	194	102	140	436	0	0	0
15	1,071,604	329,293	15,963	4,152	27.3%	1,132	11,016	47.5%	5,229	540	277	342	1,159	7	0	7
16	1,887,301	651,983	39,737	6,995	30.9%	2,163	17,424	45.1%	7,865	877	256	534	1,667	1	0	1
17	1,026,699	321,378	17,795	3,727	37.4%	1,394	9,412	43.0%	4,046	669	314	404	1,387	169	1	170
18	842,132	276,151	15,687	2,833	18.0%	511	9,182	53.9%	4,945	152	118	274	544	0	0	0
19	731,842	215,445	11,835	2,490	34.1%	850	8,137	59.9%	4,876	317	195	337	849	0	0	0
20	1,191,422	342,926	21,245	4,444	32.7%	1,452	10,381	54.9%	5,702	301	227	416	944	0	0	0
21	1,418,772	338,504	19,259	3,292	38.2%	1,257	11,108	60.2%	6,689	518	263	524	1,305	0	0	0
22	1,841,007	418,847	20,114	3,627	29.5%	1,069	17,070	55.5%	9,478	713	463	364	1,540	1	0	1
TOTAL	27,183,662	7,488,166	455,369	88,289	31.7%	27,974	246,297	52.18%	128,528	12,943	5,126	8124	26,193	1,063	135	1,198
AVG	1,235,621	340,371	20,699	4,013	32.3%	1,272	11,195	52.70%	5,842	588	233	369	1,191	48	6	54
STD	397,725	113,743	9,168	1,171	7.4%	425	4,042	6.80%	1,982	268	93	121	420	63	11	70
CV	0.32	0.33	0.44	0.29	0.23	0.33	0.36	12.90%	0.34	0.46	0.40	0.33	0.35	1.30	1.85	1.28

(1) Discharged from Psychiatric bed sections, or other acute bed sections, or Domiciliary care with psychiatric primary diagnosis (excluding addictive disorders).

(2) Either greater than 30 bed days of care per year OR 3 or more admissions.

(3) Diagnosis of schizophrenia, major affective disorder, or bipolar disorder (ICD-9 codes 295.00-296.99).

(4) The official definition of an SMI patient in VA's capacity monitoring requires 6 or more OP visits per year.

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Appendix B
MHICM Planning Material and Checklists

July 26, 2005

Director, NEPEC / VA MHICM/IPCC Project Director

MHICM Planning Guidelines

Facility or VISN Representative

1. Thank you for your interest in VA Mental Health Intensive Case Management (MHICM) programs (formerly known as Intensive Psychiatric Community Care or IPCC). In response to many inquiries about MHICM teams, we have assembled this package of materials and guidelines to help VA facility and network level planners evaluate the benefits of implementing an MHICM team. It includes:

A. Descriptive materials: 1) summary of the program's history and scientific foundation; 2) summary of the program's mission, objectives, and monitoring domains; 3) brief bibliography; 4) list of current MHICM teams.

B. Standards and Implementation Checklist: 1) outline of minimum standards and expectations for starting an MHICM team; 2) MHICM implementation checklist.

C. Report and literature: 1) FY 2004 NEPEC MHICM report; 2) 1998 IPCC outcomes paper.

2. **Would you like to learn more about Mental Health Intensive Case Management (MHICM)?**

To learn more about the history, principles, and outcomes of MHICM, review the descriptive materials and literature and VHA Directive 2000-034, "Mental Health Intensive Case Management", available at http://vaww.va.gov/publ/direc/health/direct/12000034.htm and Appendix A of the MHICM Annual Report.

3. **Are you interested in starting an MHICM team at your facility or in your VISN?**

To learn more about key elements of an MHICM team, review the enclosed minimum standards and the MHICM implementation checklist.

4. **Have you considered reconfiguring an existing staff unit into an MHICM team? How closely do your community services resemble MHICM?**

To compare a planned or existing program with MHICM services, review the enclosed minimum standards and complete the enclosed MHICM implementation checklist. Scoring your planned or existing community services team with the checklist will help us know how best to work with you.

5. **Could an MHICM team improve mental health services at your facility? Could NEPEC training and monitoring enhance the effectiveness or efficiency of an existing team?**

NEPEC publishes an annual report on MHICM teams with extensive information on program operation, as well as scientific papers in peer-reviewed journals. To learn more about NEPEC monitoring of MHICM teams, look at Chapter 2 in the FY 2004 report for tables on MHICM client characteristics, program structure, service delivery, clinical outcomes, and costs. Appendix A includes VHA Directive 2000-034, which defines MHICM services and monitoring. Appendix D provides a legend for each table. To learn more about MHICM outcomes, review the clinical and cost data from the Archives of General Psychiatry paper on the original IPCC experimental evaluation.

6. **Would you like NEPEC's assistance with starting or reconfiguring a team, training staff, or monitoring outcomes at your facility?**

To request consultation and training to establish an MHICM team, to reconfigure an existing program to MHICM, or to include an existing community treatment team in NEPEC national monitoring, please send a completed copy of the enclosed MHICM Implementation checklist to:

Robert Rosenheck MD
Northeast Program Evaluation Center (NEPEC)/182
VA Connecticut Healthcare System
950 Campbell Avenue, West Haven, CT 06516
203-937-3850.

7. Thanks again for your interest in MHICM services for veterans with serious mental illness.
We hope the enclosed materials are helpful to you.

Robert Rosenheck, M.D.
Director, NEPEC

Michael Neale, Ph.D.
VA MHICM Project Director

What is MHICM?

VHA Mental Health Intensive Case Management (MHICM) teams provide community-based psychiatric and rehabilitation services to veterans with serious mental illness who are among the most frequent and long-term users of VA inpatient mental health resources. MHICM services are characterized by high staff -client ratios, shared caseloads, assertive outreach, frequent contact in community settings, a practical problem-solving approach, and high continuity of care. Interdisciplinary teams assume primary care responsibility and provide individualized care to help veterans: 1) reduce inpatient mental health service use and cost; 2) improve community adjustment and quality of life; and 3) enhance satisfaction with services. All MHICM veterans and staff participate in standardized national monitoring of program resources, client characteristics, service delivery, and outcomes in collaboration with the Northeast Program Evaluation Center (NEPEC). Evaluation and monitoring data have demonstrated the clinical and cost effectiveness of MHICM.

MHICM services are based on principles and standards of assertive community treatment (ACT), which has been identified as an evidence-based practice for people with serious mental illnesses. VHA Directive 2000-034 defines MHICM services and monitoring within VA. Cost effectiveness studies have shown that MHICM can be effective and efficient in the VA system. MHICM staffing standards (at least 3-4 FTEE) represent a minimum relative to published ACT standards (i.e., 8-15 FTEE). A MHICM team should have sufficient staff to provide the comprehensive, intensive community-based services the standards suggest. Because MHICM teams are less richly staffed than standard ACT teams, there are occasions when clients must be referred for day treatment, medical, substance abuse, or vocational services. On the other hand, location of MHICM teams within integrated VA mental health service systems allows most veterans to receive a range of services with continuous team support and minimal fragmentation.

The ninety teams currently providing MHICM services to 4,700 veterans in 41 states nationwide are listed on the next page.

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Director, NEPEC
Michael Neale PhD
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VA Connecticut Healthcare System
950 Campbell Avenue, West Haven, CT 06516
203-937-3850.
VA Intranet: http://vaww.nepec.mentalhealth.med.va.gov
Internet: http://www.nepec.org

VHA Mental Health Intensive Case Management (MHICM) Teams (June, 2004)

AL:	Birmingham
	Tuscaloosa
	Tuskegee
AR:	Little Rock
AZ:	Phoenix
CA:	Greater Los Angeles
	Loma Linda
	Long Beach
	Palo Alto
	San Diego
	San Francisco
CO:	Denver
	Grand Junction
	Southern Colorado
CT:	West Haven
DC:	Washington
FL:	Gainesville
	Miami
	Tampa
	West Palm Beach
GA:	Atlanta
	Augusta
ID:	Boise
IL:	Chicago (West Side)
	Danville
	North Chicago
IN:	Indianapolis
	Northern Indiana (Marion/Ft. Wayne)
IA:	Central Iowa (Knoxville/Des Moines)
	Iowa City
KS:	Eastern Kansas (Topeka)
KY:	Louisville
LA:	New Orleans
ME:	Togus
MD:	Baltimore
	Perry Point
MA:	Bedford
	Brockton
MI:	Ann Arbor
	Battle Creek
	Detroit
MN:	Minneapolis
	St. Cloud
MS:	Gulf Coast (Biloxi/Gulfport)
MO:	St. Louis
MT:	Fort Harrison
NE:	Omaha
NJ:	New Jersey (East Orange/Lyons)
NM:	Albuquerque
NY:	Albany
	Brooklyn
	Buffalo
	Canandaigua
	Hudson Valley (Montrose/Castle Pt.)
	Northport
	Syracuse
NC:	Durham
	Fayetteville
	Salisbury
OH:	Akron
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	Dayton
	Mansfield
	Youngstown
OR:	Portland
PA:	Coatesville
	Lebanon
	Philadelphia
	Pittsburgh
SC:	Charleston
	Columbia
TN:	Memphis
	Mountain Home
	Tennessee Valley
TX:	Dallas
	Houston
	San Antonio
	Waco
UT:	Salt Lake City
VA:	Hampton
	Salem
WA:	American Lake
	Seattle
WV:	Martinsburg
WI:	Madison
	Milwaukee
	Tomah
WY:	Sheridan

What is the history and success of MHICM?

Mental Health Intensive Case Management (MHICM) programs represent the adaptation, within VA, of **assertive community treatment (ACT)**, a model developed in the 1970's by Arnold Marx, Leonard Stein, and Mary Ann Test in Madison, Wisconsin (1-6). ACT is one of the most heavily researched psychiatric services for people with serious mental illness, recently recommended as a state of the art intervention by the Schizophrenia Patient Outcomes Research Team (PORT) study (7-8). The intent of ACT developers was to make the comprehensive services and support of an inpatient unit available to outpatients in the community, integrated within a single team. ACT helps people to reduce psychiatric inpatient hospital use and improve community adjustment, quality of life, and satisfaction with services (9-12). Fidelity data further demonstrate that the success of a given ACT team is influenced by team adherence to the model, staff cohesiveness, and host agency support for outpatient treatment (13-16). In 1998, the National Alliance for the Mentally Ill (NAMI) adopted the Madison ACT model as a central element of its national anti-stigma campaign and many states and communities established ACT teams within their mental health systems.

Initially funded as a regional mental health demonstration program in 1987, nine original MHICM teams were compared via experimental design with standard VA aftercare services. Two-year findings revealed that MHICM veterans had significantly fewer hospital days and lower costs overall than veterans receiving standard VA treatment. Clinically, MHICM veterans scored significantly lower in psychiatric symptoms, and higher in functioning and satisfaction with services (17-18). Five-year outcomes showed sustained reductions in hospital use and improvements in psychiatric symptoms, functioning, and personal well-being for MHICM clients (18). Compared to a randomly assigned control group, 454 MHICM veterans averaged 158 fewer hospital days over five years. After accounting for program costs, the nine MHICM programs were responsible for VA cost reductions estimated at $12.8 million, or $2.6 million per year. The program was most successful at facilities that adhered to the model and showed performance improvements in other areas as well (16).

With the demonstration's success, 30 new MHICM teams were funded in 1994-95 as part of a national VA initiative that used successful teams as mentors for developing programs. The issue of VHA Directive 2000-034 prompted further program expansion with facility and network resources. System-wide monitoring data (FY 1997-03) indicate that: 1) MHICM programs serve veterans with severe, long-standing disabilities (90% psychotic diagnosis; 47% hospitalized for more than two years; mean of 88 hospital days in year preceding entry; 49% funds managed by representative payee); 2) MHICM staff provide frequent, continuous services in the community; 3) MHICM veterans show substantial reductions in hospital use (mean 54 days per veteran during the first twelve months of treatment) with commensurate reductions in inpatient costs ($48,427 per veteran for 3,190 veterans treated for twelve months); and 4) MHICM veterans show significant improvements in symptoms, functioning, quality of life, and satisfaction after six months in the program (19-21).

MHICM offers a tested and effective model for community-based treatment and rehabilitation of veterans with serious mental illness who are high users of VA psychiatric inpatient resources. It is consistent with principles underlying VA's recent reorganization that emphasize novel outpatient delivery systems, enhanced accessibility, customer satisfaction, and cost savings. On the basis of MHICM's demonstrated effectiveness, the Mental Health Strategic Healthcare Group (MHSHG) and the VA Under Secretary's Special Committee for Severely Chronically Mentally Ill Veterans (SMI Committee) have encouraged NEPEC to assist VA facilities and networks with MHICM team development by providing training, technical assistance, and monitoring.

What are the minimum standards for an effective MHICM team?

Successful implementation of MHICM requires the following explicit administrative commitments, warranted by past experience and the relative resource intensity of MHICM services:

➤ Target veterans with **serious mental illnesses** and **impaired community functioning** (typically psychotic disorders, with or without accompanying substance abuse) who are **high utilizers of VA inpatient, residential, or crisis mental health services** (for whom traditional services have not resulted in stable community adjustment);

➤ Provide a dedicated staff of **at least four clinicians** including at least one nurse as well as psychiatric and office support. Larger teams staff have generally proven to be more effective and enduring.

➤ Promote **team cooperation and morale** to enhance efficiency and continuity (crucial to team success);

➤ Identify a **team leader** whose duties include liaison with VA and community representatives, supervision of MHICM staff, and delivery of clinical services in the community;

➤ Support **frequent client contact** and **delivery of clinical services in the community**, including in vivo assessment, medication delivery, skills training, and rehabilitation services.

➤ Assure **off-hours team access** for guidance of inpatient and emergency clinical staff;

➤ Provide **ancillary resources** for safe and efficient community services, including:
-- fixed, economical **team space**, at or near the medical center/clinic;
-- dedicated **vehicles** for daily community visits by each clinician;
-- dedicated **communication technology** (beepers, cell phones) to assure staff and client safety;
-- electronic **office technology** (computers, copier, answering machine, fax machine) for organizing, charting, and monitoring clinical work;

➤ Establish **integrated links** between the MHICM team and other mental health / rehabilitation services (inpatient, outpatient, and community) to enhance service coordination;

➤ Maintain a **clear line of authority**, with the team leader represented in the mental health service or product line; and

➤ Assure **quality and accountability through monitoring** of program effectiveness and cost.

Program Objectives and Principles

MHICM services are delivered by integrated, multidisciplinary teams and are based on the Substance Abuse Mental Health Services Administration (SAMHSA) ACT standards. MHICM teams seek to deliver high quality services that:

- provide intensive, flexible community support;
- improve health status (reduce psychiatric symptoms & substance abuse);
- reduce psychiatric inpatient hospital use and dependency;
- improve community adjustment, functioning, and quality of life;
- enhance satisfaction with services; and
- reduce treatment costs.

To accomplish these objectives, MHICM teams adhere to four core treatment elements:

- Intensity of Contact. High intensity of care primarily through home and community visits, with low caseloads (seven to fifteen veterans per clinician), allowing rapid attention to crisis and development of community living skills to prevent crisis in this exceptionally vulnerable population.
- Flexibility and Community Orientation. Flexibility and community orientation with most services provided in community settings and involving integration with natural support systems whenever possible (e.g., family members, landlords, employer).
- Rehabilitation Focus. Focus on rehabilitation through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care and independent living where possible.
- Continuity and Responsibility. Identification of the team as a "fixed point of clinical responsibility" providing continuity of care for each veteran, wherever the veteran happens to be, for at least one year, with subsequent care subject to review of continuing need for intensive services.

VHA Directive 2000-034 establishes procedural guidelines for MHICM teams, operationalized in eight **minimum program standards** that serve to complement the critical performance monitors.

Minimum standard	Threshold value
Percent of veterans with psychotic diagnosis at entry	*(50% or more)*
Percent of veterans with 30 or more psychiatric inpatient days in year before entry	*(50% or more)*
Mean adjusted face-to-face contacts per week/veteran	*(1.0 or more)*
Ratio of veterans to clinical FTEE (mean caseload)	*(7:1 to 15:1)*
Percent of veterans for whom at least 60% of contacts occur in community setting	*(50% or more)*
Percent of veterans receiving psychiatric rehabilitation or skills training services	*(25% or more)*
Percent of veterans discharged from MHICM program	*(< 20%)*
Number of clinical service providers on the team	*(4.0+ FTEE).*

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VA MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM) TEAM IMPLEMENTATION CHECKLIST FOR FY 2004 ANNUAL REPORT

September 15, 2004

This is a checklist of primary criteria and recommended operational standards for use in evaluating a current MHICM team. The checklist is based on current VA criteria for MHICM teams and published CARF standards for Assertive Community Treatment (ACT). All program elements should be in place within the first year of team development. **Please indicate whether each element is in place for your team at the end of FY 2004. If "No", briefly identify a reason or obstacle to be addressed. Record site identification data and general comments or questions below and return with your team's FY 2004 Annual Report by November 15, 2004. If you have questions about checklist items, please call Mike Neale Ph.D., VHA MHICM Project Director at 203.932.5711x3696. Thank you.**

Site Identification Data:

Submitting Facility/VISN: _____

Contact Person/Title: _____

Phone: _____ Fax: _____

Address: _____

_____

_____

Alternate Contact Person/Title: _____

Phone: _____ Fax: _____

Current MHICM FTEE? _____ Current MHICM team caseload? _____

Current MHICM vehicles? _____ Percent of staff time spent in community? _____

General Comments, Questions:

VA MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM) TEAM IMPLEMENTATION CHECKLIST

September 15, 2004

PRIMARY PROGRAM CRITERIA:

Element	In Place/Planned?	Why Not?
I. MHICM Target Population		
MHICM veterans will meet all five of the following admission criteria:		
1. diagnosis of severe and persistent mental illness (e.g., schizophrenia, bipolar disorder, major affective disorder, severe PTSD) with or without substance abuse;	Yes__ No__	
2. severe functional impairment (i.e., veteran is not currently capable of successful and stable maintenance in a community living situation or participation in necessary treatment without intensive support);	Yes__ No__	
3. inadequately served by or unable to achieve a stable community adjustment with conventional clinic-based outpatient treatment or day treatment; and	Yes__ No__	
4. high hospital use (i.e. 30 or more days or 3 or more episodes of psychiatric inpatient care in the year preceding MHICM admission).	Yes__ No__	
5. clinically appropriate for MHICM rather than inpatient care.	Yes__ No__	
II. MHICM Program Description		
1. MHICM services will be delivered by an integrated, multi-disciplinary team	Yes__ No__	
with a minimum of 4.0 designated clinical FTE	Yes__ No__	
who provide services in the community.	Yes__ No__	

Element	In Place/Planned?	Why Not?

II. MHICM Program Description (continued):

Core Elements (continued)

2. MHICM services will be characterized by five core treatment elements, including:

A. high intensity of care (primarily through home & community visits) with low caseloads (7-15 veterans per 1.0 clinical FTE), rapid attention to crisis and development of community living skills to prevent crisis; Yes__ No__

B. flexibility & community orientation with most services provided in community settings and involving natural support systems (family, landlord, employer) whenever possible; Yes__ No__

C. focus on rehabilitation through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care and independent living where possible; Yes__ No__

D. identification of the team as a "fixed point of clinical responsibility" providing continuity of care for each veteran wherever s/he happens to be, for a prolonged period (initially 1 year, then based on periodic review of continuing need for services); and Yes__ No__

E. appropriate transition to standard care or lower intensity MHICM treatment when a veteran is: clinically stable, not abusing addictive substances, not relying on inpatient/ER services, capable of maintaining self in a community living situation, and independently participating in necessary treatments. Yes__ No__

III. Accountability

Each MHICM team/clinician will:

1. Utilize national DSS identifiers to designate MHICM workload; Yes__ No__
2. Maintain fidelity to MHICM operating principles and evidence-based clinical procedures; and Yes__ No__

Element	In Place/Planned?	Why Not?
III. Accountability (continued)		
3. Provide complete and timely MHICM monitoring information, including:	Yes__ No__	
A. Standard Intake Data Form (IDF) completed with all new admissions,	Yes__ No__	
B. Follow-Up Data Form (FDF) completed with each program veteran at 6 months and annually after entry,	Yes__ No__	
C. Clinical Progress Report (CPR) completed by each veteran's primary case manager at 6 months and annually after entry,	Yes__ No__	
D. FTE/Caseload Report completed monthly by the team leader,	Yes__ No__	
E. Log of veterans treated, with entry / discharge dates, and dates for completing monitoring data.	Yes__ No__	
F. Brief annual progress report on program developments, staffing, workload, projected/actual expenditures, including standards and fidelity checklists, due on November 15th each year,	Yes__ No__	
RECOMMENDED OPERATIONAL STANDARDS		
IV. Staffing		
1. Full-time team leader with master's level degree in mental health field (social work, psychology, nursing, counseling/guidance, rehabilitation) and 2000 hours (2 years) of post-degree treatment of people with serious mental illness.	Yes__ No__	
2. Minimum of eight hours (.20 FTE) psychiatrist time for every 50 vets.	Yes__ No__	
3. Minimum of 1.0 FTE RN and clearly designated, accessible nursing backup.	Yes__ No__	
4. Minimum of three-fourths of clinical staff with at least a bachelor's degree in a mental health field.	Yes__ No__	
5. Physician/nurses collaborate with other clinical staff to manage a system for prescribing/administering medications.	Yes__ No__	
6. One or more staff designated to organize daily planning of team activities.	Yes__ No__	
7. One or more staff with team chart auditing (QA) responsibilities.	Yes__ No__	

Element	In Place/Planned?	Why Not?
V. Hours of Coverage and Access		
1. Team identifies regular hours of service with at least 8 hrs on 5 days/week and evening/weekend hours as appropriate.	Yes__ No__	
2. Hospital/ER staff have 24-hour, 365-day on-call access to team for crisis, admission, discharge consultation.	Yes__ No__	
VI. Communication and Daily Planning		
1. Daily, M-F team meetings to review client status and organize/assign daily work of team. Rotated leadership.	Yes__ No__	
2. Integration of individual schedules for client contact (see treatment planning), emerging client needs, and team clinical responsibilities into daily work assignment.	Yes__ No__	
3. Recording of all client services and encounters, for purposes of auditing, workload credit, and evaluation.	Yes__ No__	
4. All staff remain accessible during work hours via beeper, pager, cellular phone.	Yes__ No__	
VII. Record-keeping		
1. Charts contain basic sections: identifying data problem list; treatment plans/reviews; progress notes; intake/history; medications/ lab results/consults; hospital summaries; clinical assessments/screenings; signed correspondence/releases; & consents/ administrative.	Yes__ No__	
2. Progress notes within local guidelines re: frequency/format, including: assessments of: clinical status, danger to self/others; medication compliance; significant events & status changes; general goals/treatment planning; client/family education; location & frequency of contact; clear goals.	Yes__ No__	
3. Initial assessment done within 4 wks of entry & in chart, covering: psychiatric/ psychological (with DSM-IV diagnosis), family/other supports, instrumental ADL, vocational, housing, medical/dental, substance abuse.	Yes__ No__	

Element	In Place/Planned?	Why Not?

VII. Record-keeping (continued)

4. Treatment plan signed by multidisciplinary team in chart within 4 wks of entry and reviewed every 6 mos or as needed. Yes__ No__

VIII. Treatment Planning

1. Weekly meetings for in-depth review of client treatment plans (1-2 clients per hour mtg), including current status & priorities, strengths & needs, short & long-term goals, staff activities & assignments. Yes__ No__
2. Multi-disciplinary treatment review schedule determined weeks ahead. Yes__ No__
3. Clear leadership of meetings. Yes__ No__
4. Problems, goals, plans, & priorities all specific & interpretable, with clear staff roles and activities. Yes__ No__
5. Treatment plan tasks and goals copied to client weekly/monthly schedule, for use in daily planning. Yes__ No__
6. Treatment plan reviewed with and co-signed by client. Yes__ No__

IX. Treatment and Rehabilitation Services

7. Primary clinician assigned for each client, although team provides multi-disciplinary treatment for each client. Yes__ No__
8. Two or more staff with complementary skills / training identified on treatment plan to provide clinical services for each client. Yes__ No__
9. Team provides a broad range of services for assigned clients as clinically indicated: advocacy; coordination; assessment & monitoring of symptoms/stressors/risks/ coping/med compliance/activities/ skill levels; planning; help/skills training for daily tasks (ADLs, shopping); family support/education, and crisis intervention (see treatment plans). Yes__ No__
10. Team initially sees each client for 2-3 substantial contacts per week on average with more frequent direct or phone contact as clinically indicated. Yes__ No__

Element	In Place/Planned?	Why Not?

IX. Treatment and Rehabilitation Services (continued)

11. On a typical working day, at least 20% of clients are seen. Yes__ No__
12. Clinicians spend 50-75% of work time providing treatment / rehabilitation services in community settings. Yes__ No__
13. Team serves as fixed point of clinical responsibility with a long-term commitment to care of each client as clinically indicated. Initial expectation is for at least one year. Yes__ No__
14. Team assumes primary clinical responsibility for assigned clients. Yes__ No__

X. Assessments

1. Assessments in charts (see IV-19). Yes__ No__
2. Assessments completed by members of multi-disciplinary team, considering specific training or expertise:
   Psychiatric..psychiatrist
   Vocational..team professional staff, voc rehab specialist
   ADL..team professional staff
   Leisure time..team professional staff
   Family..team professional staff
   Medical..RN/MD Yes__ No__

XI. Admission / Discharge Criteria

1. Admission criteria are clearly stated in policy statement and communicated to referring services, including client willingness to participate (i.e., signed releases, consents). Yes__ No__
2. Criteria for discharge or transition to lower intensity services are clearly stated in policy statement, including: clinically stable, not abusing addictive substances, not relying on extensive inpatient or emergency services, capable of maintaining self in a community living situation, and independently participating in necessary treatments. Yes__ No__

Element	In Place/Planned?	Why Not?

XII. VA, Community Agency, Client Relationships

1. Meetings are held periodically with leaders of VA & community services to introduce MHICM staff, review policies & procedures, and gain cooperation. E.g., VA: inpatient/outpatient mental health units/services, ER/admitting staff, security, engineering, pharmacy, volunteer service, patient advocate, benefits counselor, VSOs. E.g., Community: ER, psychiatric/detox units, psychosocial clubs, vocational rehabilitation, police, housing authority, residential facilities, crisis intervention. Yes__ No__
2. If vocational rehabilitation staff are not on team, liaison exists with voc rehab service/agency to perform assessments, provide training & support. Yes__ No__

XIII. National Evaluation Requirements

1. Clients are included in planning and evaluating team services, as clinically appropriate. Yes__ No__
2. Team completes a brief annual progress report on program developments, staffing, workload, projected/actual expenditures, including standards and fidelity checklists, due on November 15th each year. Yes__ No__
3. Each team maintains a log of veterans treated, with entry/discharge dates, and dates for completion of monitoring data. Yes__ No__
4. Designated clinician completes standard outcomes monitoring form at intake and 6 and 12 months after entry, and annually thereafter, for each veteran. Yes__ No__
5. Designated clinician or team completes clinical progress report form every 6 months after entry, for each veteran. Yes__ No__

Assertive Community Treatment Fidelity Scale

Please complete all items without an "X" for this edited scale.
The scale and contact sheet are on six pages.

Form A (1)

VA Facility Name: _____

1. Five-Digit Facility code ___ ___ ___ . ___ ___ (6)

Local name of the Team/Program:

_____ ___ ___ (8)

2. Target population (*list one letter from the categories below*) ..... _____ (9)
   A. Seriously mentally ill veterans (non substance abuse)
   B. Seriously mentally ill veterans (primarily substance abuse)

X3. Item deleted (leave response areas blank). x_____x (10)

x___ ___x (12)

X4. Item deleted (leave response areas blank).

x_____x (13)

X5. Items deleted (leave response areas blank).

x___ ___ . ___ ___x (17)
x___ ___ . ___ ___x (21)
x___ ___ . ___ ___x (25)
x___ ___ . ___ ___x (29)
x___ ___ . ___ ___x (33)
x___ ___ . ___ ___x (37)
x___ ___ . ___ ___x (41)

6. Regarding your clients:

x___ ___x (43)

A. How many veterans are currently in treatment in this program? ..... ___ ___ ___ (46)

B. How many veterans is the program designed to treat when it is operating at full capacity? ..... ___ ___ ___ (49)

X7. Item deleted (leave blank). x$___ ___ ___ ___ ___ ___ ___x (56)

X8. Items deleted (leave response areas blank).

x___ ___ ___x (59)
x___ ___ ___x (62)
x___ ___ ___x (65)

9. In what year was the program first implemented? ..... 19 or 20 ___ ___ (67)

Answer the following with the categories directly beneath the question.

10. What is the caseload of your program? ..... _____ (68)
    A. 10 or fewer clients per clinician
    B. 11—20 clients per clinician
    C. 21—34 clients per clinician
    D. 35—49 clients per clinician
    E. 50 or more clients per clinician

11. What percent of clients have contact with more than one staff member in a given week? ..... _____ (69)
    A. 90% or more
    B. 64—89%
    C. 37—63%
    D. 10—36%
    E. 10% or fewer

12. How frequently do the team members meet to plan or review services for each client? ..... _____ (70)
    A. Program meets 4—5 days/week and usually reviews each client, even if only briefly
    B. Program meets 2—3 days/week and usually reviews each client, even if only briefly
    C. Program meets 1 day/week and usually reviews each client, even if only briefly
    D. Program meets 1 day every other week and usually reviews each client, even if only briefly
    E. Program meets 1 day per month or less and usually reviews each client, even if only briefly

13. How much of the time does the program's supervisor /director/coordinator provide services to clients? ..... _____ (71)
    A. Normally, at least 50% of the time
    B. Normally, between 25% and 50% of the time
    C. Routinely as backup, or normally less than 25% of the time
    D. On rare occasions as backup
    E. Supervisor provides no direct services to clients

14. How much staff turnover has the program experienced in the *past two years*? ..... _____ (72)
    A. Less than 20%
    B. 20—39%
    C. 40—59%
    D. 60—80%
    E. More than 80%

15. At what percent of full staffing has the program been operating for the *past twelve months*? ..... _____ (73)
    A. 95% or more
    B. 80—94%
    C. 65—79%
    D. 50—64%
    E. less than 50%

16. Does the program have a defined target population and explicit admission criteria? ..... _____ (74)

A. The program actively recruits a defined population and all cases comply with explicit admission criteria.
B. The program typically actively seeks and screens referrals carefully, but occasionally bows to organizational pressure.
C. The program makes an effort to seek and select a defined set of clients, but accepts most referrals.
D. The program has a generally defined mission, but the admission process is dominated by organizational convenience.
E. The program has no set criteria and takes all types of cases, as determined outside the program.

17. Over the past six months, the highest monthly *intake* rate (that is, how many new clients have been admitted to the program) per month has been:..... _____ (75)

A. No greater than 6 per month
B. 7—9 per month
C. 10—12 per month
D. 13—15 per month
E. 16 or more per month

18. Which of the following five types of treatment services does your program offer? (*Check all that apply*)

A. Counseling/psychotherapy ..... _____ (76)

B. Housing support ..... _____ (77)

C. Substance abuse treatment ..... _____ (78)

D. Employment/ vocational rehabilitation ..... _____ (79)

E. Rehabilitative services ..... _____ (80)

19. What role does the program have in providing crisis services to its clients?..... _____ (81)

A. The program provides 24 hour coverage
B. The program provides emergency service backup; e.g., program is called, makes a decision about need for direct program involvement.
C. The program is available by telephone, predominately in a consulting role.
D. Emergency service has program-generated protocol for program clients.
E. The program has no responsibility for handling crises after hours.

20. In what percent of hospital admissions of program clients are staff involved in the decision to admit? ..... _____ (82)

A. 95% or more
B. 65—94%
C. 35—64%
D. 5—34%
E. 4% or less

21. In what percent of hospital discharge plans for program clients are program staff involved in developing the plan (planned jointly or in cooperation with the hospital staff)? ..... _____ (83)

A. 95% or more
B. 65—94%
C. 35—64%
D. 5—34%
E. 4% or less

22. What percent of program clients are discharged from the program within one year of program entry? ..... _____ (84)

A. 6% or fewer
B. 6—17%
C. 18—37%
D. 38—90%
E. 91% or more

23. What percent of time with clients is spent in the community (rather than in the office)? ..... _____ (85)

A. 80% or more
B. 60—79%
C. 40—59%
D. 20—39%
E. 19% or less

24. What percent of the team caseload is retained over a twelve month period? ..... _____ (86)

A. 95% or more
B. 80—94%
C. 65—79%
D. 60—64%
E. 59% or less

25. Does the program use street outreach and/or legal mechanisms (such as representative payees, probation/parole, outpatient commitment) to engage clients, as clinically indicated? ..... _____ (87)

A. The program has a strategy that includes street outreach and legal mechanisms whenever appropriate
B. The program has a strategy and uses most of the mechanisms that are available
C. Program attempts outreach but uses legal mechanisms only as convenient
D. Program makes initial attempts to engage but generally focuses efforts on most motivated clients.
E. The program almost never uses street outreach.

26. On average, how much service time does each client receive per week? ..... _____ (88)

A. 2 hours or more
B. 85—119 minutes
C. 50—84 minutes
D. 15—49 minutes
E. 14 minutes or less

27. On average, how many service contacts are made with each client per week? ..... _____ (89)

A. 4 or more per week
B. 3 per week
C. 2 per week
D. 1 per week
E. less than 1 per week

28. For clients who have a support network, such as family, landlords, or employers, on average how many staff contacts are made with members of support network per month? ..... _____ (90)

A. 4 or more per month
B. 3 per month
C. 2 per month
D. 1 per month
E. less than 1 per month

29. For clients with a substance use disorder, how many minutes per week of substance abuse treatment do they receive from program staff? ..... _____ (91)

A. 24 minutes per week or more
B. 17—23 minutes per week
C. 10—16 minutes per week
D. 3—9 minutes per week
E. 2 minutes per week or fewer

30. What percent of clients with a substance use disorder attend group treatment that is provided by program staff? ..... _____ (92)

A. 50% or more
B. 35—49%
C. 20—34%
D. 5—19%
E. 4% or fewer

31. For clients with both serious psychiatric illness and a substance use disorder, to what extent does the program employ an integrated "dual disorders" model that is stage-wise, non-confrontational, follows behavioral principles, considers interactions of mental illness and substance abuse, and has gradual expectations of abstinence) ? . _____ (93)

A. The program is fully based on such DD treatment principles, with treatment provided by program staff
B. The program primarily uses such a DD model, with some substance abuse treatment provided outside the program
C. The program uses a mixed model, including both DD and non-DD principles
D. The program uses primarily a traditional model
E. The program is fully based on a traditional model

32. What DSS Identifiers (formerly called "stop codes") are used to document the work of this program?

A. First DSS identifier (typically 552) ___ ___ ___ (96)

B. Second DSS identifier (typically 546) ___ ___ ___ (99)

C. Third DSS identifier (if applicable) ___ ___ ___ (102)

Contact person or Person completing this form:

Name _____

Telephone number (with area code and extension): ( ) _____ x _____

Fax number: ( ) _____

Email (Internet) Address: _____

Address information (street, building, mail stop, city, state, zip):

_____

_____

_____

If you have questions about the survey or items, please contact:
Mike Neale PhD: (203) 932-5711 x 3696

General comments accompanying the survey are welcome.

Please attach the survey to the Annual Report.

Appendix C
Outlier Review Request and Form

July 26, 2005

Director, NEPEC / VA MHICM Project Director

FY 2004 Performance and Minimum Standards Outlier Review

MHICM Program Directors, Clinical and Clerical Staff

1. DRAFT Tables 2-1 to 2-32 for the FY 2004 MHICM National Performance Monitoring Report, have been placed on the NEPEC intranet page, http://vaww.nepec.mentalhealth.med.va.gov/, for field review, along with Appendix D which provides a legend for each table and variable. We are also forwarding a copy of the relevant files by Outlook e-mail. As with the FY 2003 Report, MHICM performance and critical monitors are listed in Table 2-1 and data are presented in Adobe Reader (.pdf) formatted Tables 2-2 to 2-32. You may need to download a more recent version of Adobe Acrobat Reader to view or print them. A download link for the software is available on the NEPEC home page (see above). Please consult your local IRM office if necessary.

2. Please review your team's data on all tables and complete and return an outlier review for any shaded value on the monitoring and minimum standards tables. Outlier values are those for which a team's value exceeds the threshold for a critical monitor. Outliers in the *desired* direction, underlined in **bold**, require no response. Outlier values in the *undesired* direction are shaded in Tables 2-2 to 2-25 and outlined in summary tables (2-27 to 2-32) for each of the four monitoring domains (structure, client, service delivery, outcome) and the eight Minimum Program Standards.

3. **Each team is asked to review team values on all tables for accuracy and to identify each monitor or minimum standard for which the team is an outlier. For each outlier in the undesired direction, please complete an outlier review summary: 1) Identify the monitor; 2) Select a reason for outlier status; and 3) provide a brief explanation or summary of plans to correct the team value. Teams with outlier values in FY 2004 may want to consider adjusting team resources or operation to bring performance within the desired range for FY 2005.**

4. **Only negative (shaded) outliers for critical monitors indicated in the Outlier Summary Tables {Tables 2-27 through 2-32} require formal outlier response using the outlier review form provided with the FY 2004 draft tables.** Currently, that does not include outliers indicated for ACT Fidelity, Housing Independence, 6/12/18/24-month hospital use, IADLs, or Service Satisfaction. We have provided outlier feedback on these additional variables to assist your team in planning and to indicate areas where changes may be necessary to improve performance

5. If you have questions or comments about a particular measure or criterion value, please note them on the review form or send them separately. Please refer questions about the tables or outlier review to Mike Neale (203.932.5711x3696) and return the completed review forms to NEPEC by Fax (203.937.4762) or mail (NEPEC/182, VA Connecticut HCS, 950 Campbell Avenue, West Haven, CT 065176), by **Friday, April 29th, 2005**.

6. Thank you all for your dedicated efforts on behalf of veterans with serious mental illness.

(Signed) (Signed)

Robert Rosenheck, M.D. Michael Neale, Ph.D.

MHICM Outlier Review, FY 2004

This form asks the 71 **VA Mental Health Intensive Case Management (MHICM)** teams that are included in the FY 2004 MHICM National Performance Monitoring Report to respond to their identification as an outlier on one or more critical performance monitors and minimum program standards, based on the **DRAFT FY 2004 performance tables**. **Please refer to the DRAFT tables to identify all critical monitors and standards for which your team's performance fell outside desired values for an MHICM team**. For each outlier in the undesired direction, please select a primary reason and explain the situation and/or plans for remedy below.

Please submit your responses to Mike Neale PhD, VA MHICM Project Director at NEPEC, by Friday, April 29th, 2005. You may fax the form to 203.937.4762, mail it (Mike Neale PhD, NEPEC/182, VA Connecticut, 950 Campbell Avenue, West Haven, CT 06516, or respond via Outlook. If you have questions about specific values or the outlier review, please call Mike at 203.932.5711 x3696 or send an Outlook message. Thanks.

If you need additional pages, please make copies of the second page of this form.

MHICM SITE: _____ VA Station Code #: _____

Person completing this report: _____

Phone number: (_____) _____ ext. _____

Monitor/standard: _____

Reason for outlier status: *Please select the most important reason. If more than one applies, indicate in the narrative.*

_____ a. Legitimate differences in this site's team that do not conflict with national program goals.

_____ b. Local policies at this site that may conflict with national program goals.

_____ c. Problems in program implementation for which corrective action has been taken.

_____ d. Problems in program implementation for which corrective action has since been planned.

_____ e. Problems in program implementation for which corrective action has not yet been planned.

Explain: _____

_____

_____

_____

Copy and add more of this page as necessary VA Station Code #: _____

Monitor/Standard: _____

Reason for outlier status: *Please select the most important reason. If more than one applies, indicate in the narrative.*

_____ a. Legitimate differences in this site's team that do not conflict with national program goals.

_____ b. Local policies at this site that may conflict with national program goals.

_____ c. Problems in program implementation for which corrective action has been taken.

_____ d. Problems in program implementation for which corrective action has since been planned.

_____ e. Problems in program implementation for which corrective action has not yet been planned.

Explain: _____

_____

_____

_____

Monitor/standards: _____

Reason for outlier status: *Please select the most important reason. If more than one applies, indicate in the narrative.*

_____ a. Legitimate differences in this site's team that do not conflict with national program goals.

_____ b. Local policies at this site that may conflict with national program goals.

_____ c. Problems in program implementation for which corrective action has been taken.

_____ d. Problems in program implementation for which corrective action has since been planned.

_____ e. Problems in program implementation for which corrective action has not yet been planned.

Explain: _____

_____

_____

_____

List of Critical Monitors and Minimum Standards for Outlier Review, FY 2004 Draft Tables

Critical Monitor	Table	Column	MS#
Team Structure (Table 2-28)			
1. FTE Unfilled: more than 6 months (Y)	2-5	7	
2. Unassigned Medical Support: MD and/or RN (Y)	2-6	3	
3. Unassigned Medical Support: MD and/or RN (Y)	2-6	4	
4. Caseload Size: Mean Ratio Clients per Clinical FTEE (LT 7, GT15)	2-6	7	4
5. Team Size: # Full-time Clinical Staff (4.0+FTEE)	2-5	6	8
Client Characteristics (Table 2-29)			
6. % Clients with GTE 30 Days Hospital Yr Pre (LT 50%)	2-10	5	2
7. % Clients with Psychotic Diagnosis at Entry (GT 50%)	2-10	6	1
8. Mean GAF at Entry Exceeds 50 (GT 50)	2-11	6	
Clinical Process (Table 2-30)			
9. Tenure: % Clients Discharged (>20%)	2-12	5	7
10. Intensity: % Clients Seen GTE 1 Hour per wk (LT 1 Hr/Wk)	2-13	6	
11. Location: % Clients seen 60% or more in community (LT 50%)	2-13	7	5
12. Frequency: # Adjusted face-to-face contacts/Wk (LT 1/Wk)	2-14	9	3
13. Team provides Psychiatric Rehabilitation Services (LT 25% Vets)	2-15	6	6
Client Outcome (Table 2_31)			
14. Hospital Use: 365 Days % Change MH Days (Post-Pre Low)	2-18a	5	
15. Reported Symptoms: % Change (BSI) (High)	2-20	5	
16. Observed Symptoms: % Change (BPRS) (High)	2-19	5	
17. Quality of Life: % Change (QOL) (Low)	2-23	7	

MS#: Critical Performance Monitor is also a Minimum Standard (Table 2-32)

List of MHICM Teams Included in the FY 2004 Performance Monitoring Report

VISN VISN	Station Code STA5A	Facility Name Location
1	518	Bedford
1	523A5	Brockton
1	402	Togus
1	689	West Haven
2	528A8	Albany
2	528	Buffalo
2	528A5	Canandaigua
2	528A7	Syracuse
3	630A4	Brooklyn
3	620	Montrose
3	561A4	New Jersey
3	632	Northport
4	542	Coatesville
4	646A5	Pittsburgh
5	613	Martinsburg
5	512A5	Perry Point
6	565	Fayetteville
6	590	Hampton
6	658	Salem
6	659	Salisbury
7	508	Atlanta
7	509	Augusta
7	521	Birmingham
7	679	Tuscaloosa
7	619A4	Tuskegee
8	573	Gainesville
8	546	Miami
8	673	Tampa
10	538	Chillicothe
10	539	Cincinnati
10	541	Cleveland
10	757	Columbus
10	552	Dayton
10	541B2	Youngstown
11	506	Ann Arbor
11	515	Battle Creek
11	553	Detroit

11	610	Northern Indiana
12	537	Chicago-West Side
12	607	Madison
12	695	Milwaukee
12	556	North Chicago
12	676	Tomah
15	657A0	St. Louis
15	677	Topeka
16	520	Gulf Coast
16	580	Houston
16	598	Little Rock
16	629	New Orleans
17	549	Dallas
17	685	Temple (Waco)
18	501	Albuquerque
18	644	Phoenix
19	554	Denver
19	575	Grand Junction
19	660	Salt Lake City
19	666	Sheridan
19	567	Southern Colorado
20	663A4	American Lake
20	531	Boise
20	648	Portland
20	663	Seattle
21	640	Palo Alto
21	662	San Francisco
22	691	Greater Los Angeles
22	664	San Diego
23	636A8	Iowa City
23	636A7	Knoxville
23	618	Minneapolis
23	636	Omaha
23	656	St. Cloud

Appendix D
Legend for MHICM Summary Report Tables

This appendix details the source and creation of variables included in national NEPEC monitoring of the 71 MHICM teams included in the 8th MHICM National Performance Monitoring Report for FY 2004. Site-by-site values for these variables are described in Chapter 2 of the report and presented in Tables 2-1 to 2-26, Figures 2-1 to 2-6 and Appendices E-H. Text and tables are organized into domains of program structure, client characteristics, service delivery, clinical outcomes, and unit costs. Data for this report represent 4,761 veterans who received services and for whom follow-up data were available completed between October 1, 2003 and September 30, 2004.

Monitors for original MHICM teams are based on data for reduced numbers of recently entered clients and may not accurately represent values for their entire client population. For each variable, outliers were identified by tests of significance ($p<0.05$) between the least square mean of the change score for a given team and the median site score. Outliers in undesired direction are indicated by shaded values and in the desired direction by **bold, underlined** values. Outliers are boxed in summary Tables 2-27 through 2-32. Team responses to outlier values are reported in Table 2-33. **Note: Seventy-one teams with 10 or more veterans who had Baseline (IDF) and Follow-up (FDF/CPR) data from "30 series" forms were included in analyses for this report.**

TO ASSIST WITH INTERPRETATION, SEE THE ACRONYM LIST AT THE END OF THIS APPENDIX

TABLE SUMMARY DATA (AT THE BOTTOM OF MOST TABLES)

ROW HEADING	COMPUTATION DESCRIPTION
ALL SITES	Overall sum or mean across all veterans for all MHICM teams included in the analysis.
SITE AVERAGE	Team mean or average for the 71 site values presented in the table above.
SITE STD. DEV.	Standard deviation from the mean for all site values presented in the table above.

Table 2-1: VA MHICM Program Monitors

Column Heading	Source/Variable and Computation Description
Monitoring Domain	Area addressed by monitoring variable (Structure/Client/Process/Outcome/Cost).
Program Monitor	Monitoring variable derived from MHICM interviews, ratings, or centralized VA data.
Unit	Unit of measurement for monitoring variable.
Report Table	Number of report table presenting data on a given monitoring variable.
Program Objective	Program objective (1-6) addressed by monitoring variable (see Appendix B).
Critical Monitor	Indicator of critical status for comparison and outlier identification.

Table 2-2: MHICM Programs through FY 2004

Column Heading	Source/Variable and Computation Description
VISN	Veterans Integrated Service Network number.
Site Name	Name/Location of host facility or healthcare system.
Site Code	Host Facility Station Code, including 5-digit station code numbers for consolidated facilities.
Site Type	GM&S: General Medical and Surgical facility; NP: Former Neuro-Psychiatric facility.
MHICM Startup Year	Year team began accepting veteran clients.

Table 2-3: Allocated Staff and Funds (Original Dollars)

Column Heading	Source/Variable and Computation Description
	Source: MHSHG Resource tables
Allocated FTE	Original allocation of positions for MHICM services (excludes local contributions).
Personal Service	Original allocation of recurring Personal Service funds (salary and benefits).
All Other	Original allocation of recurring All Other funds (supplies, leased equipment).
Admin. Support	Original allocation of recurring Administrative Support funds (use at local discretion).
Total Program $	Original allocation of Total funds.
Row Heading	Computation Description
All Sites	Overall sum or mean across all individuals or MHICM teams included in the analysis.
Site Average	Team mean or average for the 71 site values presented in the table above.
Site S.D.	Standard deviation from the mean for all site values presented in the table above.

Table 2-4: FY 2004 Program Expenditures

Column Heading	Source/Variable and Computation Description
	Source: FY 2004 site-generated progress reports.
FY 04 Filled FTE	FY 2004 reported MHICM filled FTE.
FY 04 P/S Expend.	FY 2004 reported expenditure of MHICM Personal Service funds.
FY 04 AO Expend.	FY 2004 reported expenditure of MHICM All Other funds.
FY 04 Total Expend.	FY 2004 reported Total expenditure of MHICM funds.

Table 2-5: Utilization of Staff Resources

Column Heading	Source/Variable and Computation Description
	Source: September, 2004 Monthly FTE/Caseload Report
Allocated FTE	MHICM FTE ceiling, adjusted to include locally funded positions.
FY Filled FTE	MHICM positions reported filled as of September 30, 2004.
% FTE Utilized	Percent MHICM positions reported filled as of September 30, 2004.
Sept. Clinical FTE	Positions available to provide MHICM case management services as of September 30, 2004.
	Shaded values are below the MHICM standard of 4.0 Clinical FTEE.
FTE Unfilled GTE 6 mos.	Yes = one or more MHICM positions unfilled for 6 or more months.
	Shaded values had one or more positions unfilled for 6 months or more.
Assigned non-MHICM	Yes = one or more MHICM staff detailed to non-MHICM work.
	Shaded values have one or more staff detailed to non-MHICM work..

Table 2-6: Clinical Staff and Caseload

Column Heading	Source/Variable and Computation Description
	Source: September, 2004 monthly FTE/Caseload Summary
Medical Support MD	Y = psychiatrist assigned to MHICM team.
	Shaded values indicate the team does not have an assigned psychiatrist.
Medical support RN	Y = nurse-case manager assigned to MHICM team.
	Shaded values indicate the team does not have an assigned nurse-case manager.
Clinical FTE	Positions available to provide MHICM case management services.
9/04 Total # Vets	MHICM veterans as of September 30, 2004.
9/04 Caseload / Clin FTE	Average number of veteran clients per clinical FTE.
	Shaded values indicate the mean caseload is outside MHICM standard range of 7:1 to 15:1.
Target Caseload	Min: minimum caseload ratio of 7 clients per clinical FTE (VHA Directive 2000-034).
	Max: maximum caseload ratio of 15 clients per clinical FTE (VHA Directive 2000-034).

Table 2-7: Demographic Characteristics of Veterans at Intake

Column/Row Heading	Source/Variable and Computation Description
	Source: Initial Data Form (IDF), Form 34.
Overall	All sites combined (N=71 teams in FY 2004 are represented in this report.)
GM&S	General medicine & surgery facilities (N=46 teams).
NP	Former neuro-psychiatric facilities (N=25 teams).
Gender	% MHICM veterans who are male or female (34: Face sheet).
Age	Mean age of MHICM veterans (34: Face).
Race	% MHICM veterans from different racial/ethnic backgrounds (34: Face).
Marital status	% MHICM veterans with different marital histories (34: Face sheet).
Combat exposure	% MHICM veterans reporting exposure to combat (34: #25).
Employment Last 3 yrs	% MHICM veterans with different employment histories in past 3 years (34: #31).

Table 2-8: Entry Criteria Information

Row Heading	Source/Variable and Computation Description
	Source: IDF 34.
Mn hospital days 1 yr pre	Mean days spent in VA hospital; year before entry (34: #17).
Inpt psych unit referral	% MHICM veterans referred for MHICM treatment directly from inpatient unit (34: #16).
Primary psych diagnosis	% MHICM veterans with a DSM-IV psychiatric diagnosis at entry (34: #21).
GTE 30 days in hospital	% MHICM veterans with 30+ psychiatric hospital days in year before entry (34: #17; PTF). *GTE means "Greater than or equal to."*
Dual diagnosis at entry	% MHICM veterans with co-morbid substance abuse diagnosis at entry (34: #21).
Diagnosis	% MHICM veterans meeting various diagnostic criteria at entry (34: #21).
Disability/Pension	% MHICM veterans receiving any compensation or disability funds (34: #26-9).
SC Disability	% MHICM veterans with VA service-connected disability (34: #26; Face).
NSC Pension	% MHICM veterans receiving VA non-service connected pension (34: #26; Face).
SSI	% MHICM veterans receiving Social Security Supplemental Income (34: #27).
SSDI	% MHICM veterans receiving Social Security Disability Income (34: #28).
Payee	% MHICM veterans with a designated representative payee for funds (34: #29).

Table 2-9: Receipt of Disability Compensation or Pension Income

Column Heading	Source/Variable and Computation Description
	Source: IDF 34.
VA Compensation %	% MHICM veterans receiving VA service-connected compensation (34: #26).
NSC Pension %	% MHICM veterans receiving non-service-connected pension (34: #26).
SSI %	% MHICM veterans receiving Social Security Supplemental Income (34: #27).
SSDI %	% MHICM veterans receiving Social Security Disability Income (34: #28).
Rep Payee %	% MHICM veterans with a designated representative payee for funds (34: #29).
Any Disability %	% MHICM veterans receiving any compensation/disability pension (34: #26-29).

Table 2-10: Entry Criteria Information by Site

Column Heading	Source/Variable and Computation Description
	Source: IDF 34.
Lifetime Hosp GT 2 yrs	% MHICM vets reporting lifetime psychiatric hospital use GT 2 yrs (34: #190).
Years since 1st Hosp	Mean years since first psychiatric hospitalization (34: #47).
GTE 30days Hosp. yr pre	% MHICM veterans with 30+ VA hospital days; year before entry (34: #17). Shaded values: Less than 50% of veterans have 30+ hospital days prior to entry. **Bold values: 100% of veterans have 30+ hospital days in year prior to entry.**
Psychotic Dx at Entry	% MHICM veterans with psychotic diagnosis at entry (34: #22), including: schizophrenia, schizo-affective disorder, other psychosis, and bipolar disorder. Shaded values: Less than 50% of veterans with diagnosis of psychosis at entry. **Bold values: 100% of veterans have diagnosis of psychosis at entry.**
Dual diagnosis	% MHICM veterans with co-morbid substance abuse diagnosis at entry (34: #21).

Table 2-11: Clinical Status at Entry

Column Heading	Source/Variable and Computation Description
	Source: Initial Data Form (IDF), Form 34.
Inpatient at Entry	% veterans entering MHICM from inpatient status (34: #16; 24: na).
Low IADL	% MHICM veterans scoring 1 or 2 on one of four Form 34 IADL items (#121,123-125).
BPRS Mean	Mean BPRS Total score (sum 18 items) at entry (34: #265-283).
	Note: "1" added to each BPRS item to conform with current reporting conventions.
GAF Mean	Average GAF score at entry (34: #284).
	Shaded values: Mean GAF score at entry is 50 or higher.

Table 2-12: MHICM Program Tenure

Column Heading	Source/Variable and Computation Description
	Source: Clinical Progress Report (CPR), Form 39; NEPEC Access files.
Total Vets	# MHICM veterans with FDF between 10/1/02 and 9/30/04 (Access/SAS).
Vets Discharged #	# Follow-up veterans discharged by program as of September 30, 2004 (Access).
Vets Discharged %	% Follow-up veterans discharged as of September 30, 2004 (#DC'd / Total # Vets).
	Shaded values: More than 20% of team veterans were discharged during the fiscal year.
Mean Days in Program	Average # Days in MHICM per veteran (FDF date minus IDF date).

Table 2-13: Pattern of Service Delivery

Column Heading	Source/Variable and Computation Description
	Source: Clinical Progress Report (CPR), Form 39; NEPEC Access files.
Total Vets	# MHICM veterans in FY 2004 (Access/SAS).
Contact Frequency	Face-to-face: % MHICM veterans with weekly or more frequent contact (39: #40).
	Telephone: % MHICM veterans with weekly or more frequent contact (39: #41).
Intensity	% MHICM veterans with GTE one hour of weekly contact (39: #45).
	Shaded values: Less than half of clients have weekly or more frequent contact.
	Bold values: More than 78% of clients have weekly or more frequent contact.
Location	% MHICM veterans with GTE 60% of contacts in the community (39: #37).
	Shaded values: Less than half of veterans have 60% or more of contact in the community.
	Bold values: 98-100% of clients have 60% or more of their contact in the community.
All Site v. Site Average	Mean value for all vets combined (N=4,761) v. site scores (N=71) in the table.

Table 2-14: Outpatient Clinic Visits

Column Heading	Source/Variable and Computation Description
	Source: VA Outpatient Clinic (OPC) stops reported b/w 10/1/01 and 9/30/03.
Total Vets seen	# MHICM veterans with a MHICM stop code during FY 2004 (Access/SAS.
Mean contacts/Vet: 12mo.	Total: Avg. sum all MHICM encounters recorded under DSS identifiers 546 & 552 per vet.
	Telephone: Avg. sum telephone encounters recorded under DSS identifier 546 per vet.
	Face-Face: Avg. sum face-to-face encounters recorded under DSS identifier 552 per vet.
Amount time in program	Mean proportion of period (10/1/03-9/30/04) veterans spent in MHICM (per site).
	Used to standardize all veterans and sites at 12 months. of program participation.
Adjusted face-face/vet	Mean face-to-face contacts, divided by the team's 'amount of time in program'.
Adjusted face-to-face contacts/wk/vet	Mean face-to-face contacts, adjusted for each team's amount of time in program, then divided by 52 weeks to get a contacts per week value.
	Shaded values: Mean of team contact is less than 1.0 per week per veteran.
	Bold values: Mean of team contact exceeds 1 standard deviation above the mean.

Table 2-15A & B: Therapeutic Services

Column Heading	Source/Variable and Computation Description
	Source: Clinical Progress Report (CPR), Form 39.
Follow-up Vets	# MHICM veterans with FDF between October 1, 2003 and September 30, 2004.
Supportive Contact	% veterans receiving supportive contact services from MHICM (39: # 13;).
Active Monitor	% veterans receiving active monitoring services from MHICM (39: #15).
Rehabilitation	% veterans receiving rehabilitation services from MHICM (39: #16).
	Shaded values: Less than 25% of veterans receive rehabilitation services.
	Bold values: Percent of clients receiving rehabilitation services exceeds 1 standard deviation above the mean.
Psychother Relationship	% veterans receiving psychotherapeutic treatment from MHICM (39: #18).
Social/Rec Activities	% veterans in social/recreational activities organized by MHICM (39: #19).
Crisis Intervent	% veterans receiving crisis intervention services from MHICM (39: #23).
Medicatn Mgmt	% veterans whose medications were managed by MHICM (39: #24).
Medical Screen	% veterans screened for or treated for medical problems by MHICM (39: #25).
Seen for Sub. Abuse	% veterans receiving substance abuse treatment from MHICM (39: #26).
Housing Support	% veterans assisted with locating or managing housing by MHICM (39: #27).
Vocational Support	% veterans assisted with locating or maintaining a job by MHICM (39: #30).

Table 2-16: Client-Rated Therapeutic Alliance

Column Heading	Source/Variable and Computation Description
	IDF 34; Follow-up Data Form (FDF), Form 37.
	MHICM alliance at 6 mos. was compared with pre-entry alliance with primary clinician.
Pre-Entry N	MHICM veterans with IDF entry interview data on this measure.
Pre-Entry Mean	Average score for this measure at entry (34: #219-225).
Follow-up Mean	Average score for this measure at 6 months (37: #179-185), adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
	Shaded values: Adjusted change value is significantly lower ($p<0.05$) than median site.
	Bold values: Adjusted change value is significantly higher ($P<0.05$) than median site.
Percent Change	Change at Follow-up divided by Pre-Entry Mean to get adjusted percent change.

Table 2-17: Fidelity to Assertive Community Treatment Model

Column Heading	Source/Variable and Computation Description
	DACTS self-report by sites; confirmed with other available data.
Human Resources	Average program score on 7 human resources items.
Organiz□l Boundaries	Average program score on 7 organizational boundaries items.
Services	Average program score on 6 nature of services items.
Sub.Abuse Tx	Average program score on 3 substance abuse treatment items.
Total Score	Total program score: sum of 23 DACTS items.
Avg. Score	Average program score: mean of 23 DACTS items. Original DACTS contains 26 items.
	Compare VA scores to averages, NOT to totals, for non-VA programs.
	Shaded values exceed 1 standard deviation below the mean site (undesired).
	Bold values exceed 1 standard deviation above the mean site (desired).

Table 2-18: VA Hospital Use: 183 Days Before and After Program Entry

Column Heading	Source/Variable and Computation Description
	Source: PTF through 9/30/04.
Total N FY 04	# MHICM veterans as of 9/30/04.
N 183 Days	# MHICM veterans with 183 or more days in program (entered by 3/31/04).
Pre-Entry MH Days/Vet	Mean mental health hospital days per veteran in 183 days before MHICM entry.
Post-Entry MH Days/Vet	Mean mental health hospital days per veteran in 183 days after MHICM entry.
Change MH Days/Vet	Mean change in mental health hospital days (Post- minus pre-MHICM entry).
	Shaded values exceed 1 standard deviation from mean in direction of fewer days/lower %.
	Bold values exceed 1 standard deviation from mean in direction of more days/higher %.
% Change MH Days/Vet	Mean % change in mental health days (Change MH Days/Pre-IDF MH Days).
Inpt MH Per Diem FY04	Mean national inpatient mental health per diem cost (NMHPPMS): $1,011 [hidden col.]
Change IP MH Cost/Vet	183-day Inpatient MH reduction per MHICM vet (Inpt MH Per Diem x Change MH Days).
	Cost change data are unadjusted for inflation and do not fully represent cost reductions achieved for veterans at original MHICM sites.

Table 2-18a: VA Hospital Use: 365 Days Before and After Program Entry
Table 2-18b: VA Hospital Use: 548 Days Before and After Program Entry
Table 2-18c: VA Hospital Use: 730 Days Before and After Program Entry
The format for these Tables is identical to that for Table 2-18, with increasing Pre- and Post-Entry time frames: a) 365 days; b) 548 days; and c) 730 days. For each table, data are reported only for veterans with sufficient time in the program to allow that Pre-Post comparison. **Program entry is defined by Initial Data Form (IDF) completion date**.

Table 2-19: Brief Psychiatric Rating Scale (Observed symptoms)

Column Heading	Source/Variable and Computation Description
	IDF 34; Follow-up Data form (FDF), Form 37.
	Note: "1" added to each BPRS item to conform with current reporting conventions.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean BPRS Total score (sum 18 items) at entry (34: #265-283).
Follow-up Mean	Mean BPRS Total score (sum 18 items) at follow-up (37: #225-243), adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change.
	Shaded values: Adjusted change value is significantly higher ($p<0.05$) than median site.
	Bold values: Adjusted change value is significantly lower ($P<0.05$) than median site.

Table 2-20: Symptom Severity (Client-reported Brief Symptom Inventory Items)

Column Heading	Source/Variable and Computation Description
	IDF 34; FDF 37 Schizophrenia Outcomes Module & Brief Symptom Inventory items (Note: Replication site variables are scaled differently and not included.)
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean symptom score at entry (34: #51-80).
Follow-up Mean	Mean symptom score at follow-up (37: #30-59), adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change.
	Shaded values: Adjusted change value is significantly higher ($p<0.05$) than median site.
	Bold values: Adjusted change value is significantly lower ($P<0.05$) than median site.

Table 2-21: Global Assessment of Functioning (GAF; DSM-IV Axis V)

Column Heading	Source/Variable and Computation Description
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	GAF score at entry (34: #284).
Follow-up Mean	Mean GAF score at follow-up (39: #116) adjusted for site, time in program, baseline value, and 11 baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p<0.05$) than median site. **Bold values: Adjusted change value is significantly higher ($P<0.05$) than median site.**

Table 2-22: Instrumental Activities of Daily Living (Schizophrenia Outcomes Module items)

Column Heading	Source/Variable and Computation Description
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean IADL score at entry (34: # 114-125).
Follow-up Mean	Mean IADL (37: #77-88) score at follow-up adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p<0.05$) than median site. **Bold values: Adjusted change value is significantly higher ($P<0.05$) than median site.**

Table 2-23: Quality of Life (Lehman QOLI Delighted-Terrible items)

Column Heading	Source/Variable and Computation Description
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Mean	Mean QOL scores at entry (34: #23,128,136,147,150,240).
Follow-up Mean	Mean QOL scores (37: #14,91,99,110,113,201) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p<0.05$) than median site. **Bold values: Adjusted change value is significantly higher ($P<0.05$) than median site.**

Table 2-23a: Housing Independence Index (NEPEC scale)

Column Heading	Source/Variable and Computation Description
	IDF 34; FDF 37: Days in each setting were multiplied by weight for restrictiveness.
Pre-Entry N	MHICM veterans with entry interview data on this measure.
Pre-Entry Sum	Sum of weighted HOUI items at entry (34: #138*4, 140*3, 142*2, 144*1, 146*0).
Follow-up Sum	Sum of weighted HOUI items at follow-up (37: #101*4, 103*3, 105*2, 107*1, 109*0) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p<0.05$) than median site. **Bold values: Adjusted change value is significantly higher ($P<0.05$) than median site.**

Table 2-24: VA Mental Health Services Satisfaction (3 item)

Column Heading	Source/Variable and Computation Description
	IDF 34; FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on VA Mental Health services satisfaction.
Pre-Entry Mean	Sum VA MH Satisfaction score at entry (34: #232,235,239).
Follow-up Mean	Sum VA MH Satisfaction score at follow-up (37: #193,196,200) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p<0.05$) than median site. **Bold values: Adjusted change value is significantly higher ($P<0.05$) than median site.**

Table 2-25: Satisfaction with VA MHICM Services (vs. VA Mental Health Services; single items)

Column Heading	Source/Variable and Computation Description
	FDF 37.
Pre-Entry N	MHICM veterans with entry interview data on VA mental health services satisfaction.
Pre-Entry Mean	Mean VA MH services satisfaction score at entry (34: #228).
Follow-up Mean	Mean MHICM Satisfaction score at follow-up (37: #190) adjusted for site, time in program, baseline value, and eleven other baseline covariates.
Change at Follow-up	Least squares mean derived from analysis of covariance, including site, time in program, baseline value, and eleven other baseline covariates.
Percent Change	Change to Follow-up divided by Pre-Entry Mean to get adjusted percent change. Shaded values: Adjusted change value is significantly lower ($p<0.05$) than median site. **Bold values: Adjusted change value is significantly higher ($P<0.05$) than median site.**

Table 2-26: MHICM Unit Costs (per Veteran, FTE, Visit)

Column Heading	Source/Variable and Computation Description
	Source: FY 2004 Site-generated annual progress reports, OPC stop codes.
FY04 Total Expenditures	FY 2004 reported total expenditure of MHICM funds.
Total Vets	# MHICM veterans receiving MHICM services in FY 2004 (OPC).
Cost per Veteran	Annual cost per MHICM veteran (FY 04 Total Expenditures divided by Total Vets)
FY04 P/S Expenditures	FY 2004 reported personal service expenditures.
FY04 Filled FTE	MHICM positions reported filled as of September 30, 2004.
Cost per FTE	Annual cost per MHICM FTE (FY 04 P/S Expenditures divided by Total FTE)
Adj. Total Visits/Vet/Yr	Total MHICM stop code visits (per veteran), adjusted for 52 weeks.
Total Visits/Site/Yr	Adjusted Total Visits/Vet/Yr multiplied by Total Vets to get Total Team Visits for FY 2004.
Cost per Visit	Cost per visit (FY 04 Total Expenditures divided by Total Visits per Yr)

Table 2-27: Site Performance on MHICM Critical Monitors

Column Heading	Source/Variable and Computation Description
	Source: Critical monitor outliers identified on tables 2-1 to 2-24.
Structure	# of 5 critical monitors in tables 2-2 to 2-6 in undesired direction.
Client	# of 3 critical monitors in tables 2-7 to 2-11 in undesired direction.
Process	# of 5 critical monitors in tables 2-12 to 2-17 in undesired direction.
Outcome	# of 4 critical monitors in tables 2-18 to 2-25 in undesired direction.
Site Total	Total # of 17 critical monitors in tables 2-2 to 2-25 in undesired direction.

Table 2-28: Outliers for Team Structure Monitors

Column Heading	Source/Variable and Computation Description
	Source: Outliers from Tables 2-5 and 2-6.
FTE Unfilled	Yes = one or more MHICM positions unfilled for 6 or more months (Table 2-5).
Unassigned Medical	N = physician (MD) or nurse-case manager (RN) not assigned to MHICM team (2-6).
Caseload Size	Total # MHICM veterans as of 9/30/03 divided by Clinical FTE as of 9/30/03 (2-6).
Team Size	Clinical FTE as of September 30, 2004 (Monthly FTE/Caseload Report) (2-5).
Total Team Outliers	# Team Structure monitors for which team value is an outlier (range: 0-5).
# Applicable Monitors	# Team Structure monitors that applied to team in FY 2004 (range: 0-5).
% Outliers/Applicable	# team outliers divided by # applicable monitors.

Table 2-29: Outliers for Client Characteristics Monitors

Column Heading	Source/Variable and Computation Description
	Source: Outliers from Tables 2-10 and 2-11.
% Clients GTE 30 Days	% MHICM veterans with 30+ VA hospital days in year before entry (2-10).
% Clients Psychotic Dx	% MHICM veterans with psychotic diagnosis at entry (2-10).
Mean GAF at Entry	Average GAF score at entry for veterans seen by team (2-11).
Total Team Outliers	# Client Characteristics monitors for which team value is an outlier (range: 0-3).
# Applicable Monitors	# Client Characteristics monitors that applied to team in FY 2004 (range: 0-3).
% Outliers/Applicable	# team outliers divided by # applicable monitors.

Table 2-30: Outliers for Clinical Process Monitors

Column Heading	Source/Variable and Computation Description
	Source: Outliers from Tables 2-12, 2-13, 2-14 and 2-15.
Tenure	% veterans discharged as of September 30, 2004 (2-12).
Intensity	% veterans with one hour or more of weekly contact (2-13).
Location	% veterans with 60% or more of contacts in the community (2-13).
Frequency # Adjusted	Mean face-to-face visits, adjusted for each team's amount of time in program, then divided by 52 weeks to get a visits per week value (2-14).
Team provides...Rehab	% veterans receiving rehabilitation services from MHICM team (2-15A).
Total Team Outliers	# Clinical Process monitors for which team value is an outlier (range: 0-5).
# Applicable Monitors	# Clinical Process monitors that applied to team in FY 2004 (range: 0-5).
% Outliers/Applicable	# team outliers divided by # applicable monitors.

Table 2-31: Outliers for Client Outcome Monitors

Column Heading	Source/Variable and Computation Description
	Source: Outliers from Tables 2-18a, 2-19, 2-20 and 2-23.
365 Days % Change	Mean % change in mental health days after 365 days (2-18a).
Reported Symptoms %	Change in BSI at Follow-up (2-20).
Observed Symptoms %	Change in BPRS at Follow-up (2-19).
Quality of Life %	Change in QOL at Follow-up (2-23).

Table 2-32A&B: Outliers for Minimum Standards

	Source: Selected Outliers from Tables 2-5, 2-6, 2-10, 2-12, 2-13, 2-14, and 2-15.
% Clients Psychotic Dx	% vets with psychotic diagnosis at entry *(Threshold: 50% or more)* (2-10).
% Clients GTE 30 Days	% vets with 30+ psychiatric inpatient days in year pre-entry *(50% or more)*(2-10).
# Adjusted Face-to-face	Mean adjusted face-to-face visits per week per veteran *(1.0 or more)*(2-14).
Caseload Size	Ratio of veterans to clinical FTE (mean caseload as of 9/30/01)*(7:1 to 15:1)* (2-6).
% Clients seen 60%…	% vets for whom 60+% of visits occur in community *(50% or more)* (2-13).+
Team provides...Rehab	% vets receiving psychiatric rehabilitation/skills training *(25% or more)* (2-15).
Tenure	% vets discharged from MHICM program in FY 2004 *(< 20%)* (2-12).
Team Size	# Clinical case managers on team as of 9/30/04 *(4.0+ FTEE)* (2-5).
Total Outliers	# of 8 minimum standards for which team value was an outlier (range: 0-8).
% Min Stand Outliers	% of 8 minimum standards for which team value was outlier in FY 2004.
% Outliers FY 2001	% of 8 minimum standards for which team value was outlier in FY 2001.
Change % Outliers	Change in team % outliers from FY 2001 to FY 2004.

Table 2-33 Site Outlier Review Summary

	Source: Site completed Outlier Review Forms for indicated outliers.
Site # Outliers	# of critical monitors for which team value was an outlier in undesired direction.
Reason A	# Team responses indicating "Legitimate differences in this site's team that do not conflict with national program goals".
Reason B	# Team responses indicating "Local policies at this site that may conflict with national program goals".
Reason C	# Team responses indicating "Problems in program implementation for which corrective action has been taken".
Reason D	# Team responses indicating "Problems in program implementation for which corrective action has since been planned".
Reason E	# Team responses indicating "Problems in program implementation for which corrective action has not yet been planned".
Sum of Responses	# outliers addressed in Outlier Review.

Appendix E. MHICM Case Management Services, FY 2004 (MHICM Veterans)

	Source: VA Outpatient Clinic File (Austin, TX).
MHICM Community	Visits recorded under DSS Identifier (stop code) #552, MHICM.
# Veterans	Number of veterans with at least one MHICM visit.
# Visits	Total MHICM (stop code 552) visits.
Mn Visits	Mean number of MHICM visits per veteran with at least one visit.
Low Intensity CM Visits	Visits recorded under DSS Identifier #564, General Case Management.
# Veterans	Number of veterans with at least one Low Intensity or General CM visit.
#Visits	Total Low Intensity or General CM (stop code 564) visits.
Mn Visits	Mean number of Low Intensity visits per veteran with at least one visit.
Facility Sum/Mean	Total number of veterans and overall mean of visits across all facilities.
VISN Sum/Mean	Total number of veterans and overall mean of visits across all VISNs.

Appendix F. Non-MHICM Case Management Services, FY 2004 (Non-MHICM Veterans)

	Source: VA Outpatient Clinic File (Austin, TX).
MHICM Community	Visits recorded under DSS Identifier (stop code) #552, MHICM.
Veterans (N)	Number of veterans with at least one MHICM visit.
# Visits	Total MHICM (stop code 552) visits.
Mn Visits	Mean number of MHICM visits per veteran with at least one visit.
General CM Visits	Visits recorded under DSS Identifier #564, General Case Management.
Veterans (N)	Number of veterans with at least one General/Low Intensity CM visit.
#Visits	Total General/Low Intensity (stop code 564) visits.
Mn Visits	Mean number of Low Intensity visits per veteran with at least one visit.
Facility Sum/Mean	Total number of veterans and overall mean of visits across all facilities.
VISN Sum/Mean	Total number of veterans and overall mean of visits across all VISNs.

Appendix G. MHICM Complex VERA Veterans, FY 2004

	Source: Allocation Resource Center; NEPEC Monitoring Files.
MHICM Vets	Veterans registered in MHICM program during FY 2004.
Complex VERA Vets #	Veterans identified by ARC with 41 or more MHICM stop Code 552 Visits in FY 04. Note: Additional veterans may have previously qualified for complex class status in other patient classes (e.g. chronic mental illness) based on prior VA service use or retention criteria.
Complex VERA Vets %	Percentage of MHICM registered veterans identified as MHICM Complex VERA Class.

Appendix H. MHICM Program Monitor Trends, FY 1997-2004

Source: MHICM Performance Monitoring Reports, FY 1997-2004.

FY 1997 - FY 2004 values are presented for select MHICM performance monitors, by monitoring domain, along with the percent change in values between 1997-2004.

<u>Team Structure</u>	
Teams	Total MHICM teams in FY 2004 (71 teams included in FY 2004 Report).
Clients	Total veteran clients included in FY 2004 report.
Expenditure	Total program expenditures for 71 MHICM teams in FY 2004 report.
Assigned FTEE	Total FTE assigned to 71 MHICM teams in the FY 2004 report.
Filled FTEE	Total filled FTEE for 71 MHICM teams in FY 2004 report.
% Filled	Filled FTEE divided by assigned FTE.
Staff detailed away	% of filled FTE detailed part-time to other services.
Cost/Client	Unit cost per MHICM client
Client/Staff ratio	Mean client to staff ratio (caseload size). MHICM range: 7:1 to 15:1.
<u>Client Characteristics</u>	
Age	Mean client age at entry.
Minority race / ethnicity	Percent minority race / ethnicity.
Mean hospital days yr pre	Mean hospital days per veteran in year preceding entry.
% 30+ hospital days yr pre	Percent of clients meeting minimum hospital days criterion at entry: 30+ days in prior year.
2+ yrs hospital lifetime	Percent of clients with 2 or more years of total lifetime psychiatric hospitalization.
Psychotic diagnosis	Percent clients with a primary psychiatric diagnosis with psychosis at entry.
Substance use diagnosis	Percent of clients with co-occurring substance use diagnosis at entry.
Paid employment (3yrs)	Percent of clients reporting paid employment in the three years preceding entry.
Public support income	Percent of clients receiving public support income from VA or social security at entry.
<u>MHICM Services</u>	
Contacted weekly	Percent of clients contacted weekly or more frequently.
Contacts/week	Face-to-face contacts per week adjusted for portion of year in program.
60%+ visits community	Percent of clients with 60% or more of contacts occurring in the community.
Discharged	Percent of MHICM clients discharged during FY 2004.
Client-rated Alliance	Therapeutic alliance score reported by MHICM clients at follow-up
Team ACT Fidelity Score	Mean ACT fidelity score for MHICM teams overall.
<u>Client Outcome (Follow-up)</u>	
Observed symptoms	Percent change in BPRS score from entry to follow-up.
Reported symptoms	Percent change in BSI score from entry to follow-up.
Quality of Life reported	Percent change in Quality of Life score from entry to follow-up.
Satisfaction MHICM (1-5)	Percent change in Client Satisfaction with MHICM at follow-up.
Change Inpt days (6mos.)	Change in psychiatric hospital days during first 6 months.
% Change Inpt days (6mo)	Percent change in psychiatric hospital days during first 6 months.

Acronyms

ACCESS	**MICROSOFT RELATIONAL DATABASE SOFTWARE**
ACT	**ASSERTIVE COMMUNITY TREATMENT (PROGRAM MODEL)**
ADJ	**ADJUSTED SCORE**
AVG/MN	**AVERAGE**
BPRS	**BRIEF PSYCHIATRIC RATING SCALE**
BSI	**BRIEF SYMPTOM INVENTORY**
CM	**CASE MANAGEMENT OR CASE MANAGER**
CPR	**CLINICAL PROGRESS REPORT FORM (NEPEC MONITORING FORM 39)**
DSS	**DECISION SUPPORT SYSTEM (VHA FISCAL SOFTWARE)**
DX	**DIAGNOSIS**
FDF	**FOLLOW-UP DATA FORM (NEPEC MONITORING FORM 37)**
FTE	**FULL TIME EQUIVALENT POSITION**
FY	**FISCAL YEAR**
GAF	**GLOBAL ASSESSMENT OF FUNCTIONING SCORE**
GM+S	**GENERAL MEDICINE AND SURGERY FACILITY**
GTE	**GREATER THAN OR EQUAL TO**
HOUI	**HOUSING INDEPENDENCE INDEX**
IADL	**INSTRUMENTAL ACTIVITIES OF DAILY LIVING**
IDF	**INITIAL DATA FORM (NEPEC MONITORING FORM 34)**
IDF DATE	**INITIAL DATA FORM DATE**
IP	**INPATIENT**
MAX	**MAXIMUM**
MD	**PHYSICIAN, PSYCHIATRIST**
MH	**MENTAL HEALTH**
MIN	**MINIMUM**
NEPEC	**NORTHEAST PROGRAM EVALUATION CENTER (WEST HAVEN, CONNECTICUT)**
NP	**FORMER NEUROPSYCHIATRIC FACILITY**
NSC	**NON-SERVICE-CONNECTED**
OPC	**OUTPATIENT CLINIC FILE (VHA OUTPATIENT AUTOMATED DATA, AUSTIN TX)**
PTF	**PATIENT TREATMENT FILE (VHA INPATIENT AUTOMATED DATA, AUSTIN TX)**
PRE-ENTRY	**PERIOD BEFORE ADMISSION TO MHICM**
QOL	**QUALITY OF LIFE SCALE**
RN	**NURSE**
SAS	**STATISTICAL ANALYSIS SYSTEM SOFTWARE**
SC	**SERVICE-CONNECTED**
SSI	**SOCIAL SECURITY SUPPLEMENTAL INCOME**
SSDI	**SOCIAL SECURITY DISABILITY INCOME**
TX	**TREATMENT**
YR	**YEAR**
VERA	**VETERANS EQUITABLE RESOURCE ALLOCATION (VA BUDGETING STRUCTURE)**
VHA	**VETERANS HEALTH ADMINISTRATION**
VISN	**VETERANS INTEGRATED SERVICE NETWORK (MULTI-SITE HEALTH SYSTEM)**

Appendix E
MHICM Case Management Services, FY 2004 (Registered MHICM Veterans*)

VISN	SITE CODE	SITE NAME/VISN	MHICM Visits (Stop Code 552 Visits) #Veterans	#Visits	MnVisits	Low Intensity CM Visits (Stop Code 564 Visits) #Veterans	#Visits	MnVisits
1	518	BEDFORD	128	12,142	94.9	0	0	0.0
1	523A5	BROCKTON	79	3,011	38.1	0	0	0.0
1	402	TOGUS	27	1,322	49.0	0	0	0.0
1	689	WEST HAVEN	60	4,328	72.1	0	0	0.0
		VISN 1	**294**	**20,803**	**63.5**	**0**	**0**	**0.0**
2	528A8	ALBANY	48	4,213	87.8	0	0	0.0
2	528	BUFFALO	81	3,121	38.5	0	0	0.0
2	528A5	CANANDAIGUA	93	7,462	80.2	0	0	0.0
2	528A7	SYRACUSE	50	1,726	34.5	0	0	0.0
		VISN 2	**272**	**16,522**	**60.3**	**0**	**0**	**0.0**
3	630A4	BROOKLYN	55	1,594	29.0	0	0	0.0
3	620	MONTROSE	96	5,126	53.4	2	6	3.0
3	561	NEW JERSEY	85	3,564	41.9	8	145	18.1
3	632	NORTHPORT	100	5,452	54.5	2	19	9.5
		VISN 3	**336**	**15,736**	**44.7**	**12**	**170**	**7.7**
4	542	COATESVILLE	96	4,719	49.2	47	277	5.9
4	646A5	PITTSBURGH	132	4,642	35.2	0	0	0.0
		VISN 4	**228**	**9,361**	**42.2**	**47**	**277**	**2.9**
5	613	MARTINSBURG	31	961	31.0	0	0	0.0
5	512A5	PERRY POINT	88	3,830	43.5	0	0	0.0
		VISN 5	**119**	**4,791**	**37.3**	**0**	**0**	**0.0**
6	565	FAYETTEVILLE	26	1,761	67.7	0	0	0.0
6	590	HAMPTON	57	3,755	65.9	1	1	1.0
6	658	SALEM	40	1,555	38.9	4	9	2.3
6	659	SALISBURY	35	1,877	53.6	13	84	6.5
		VISN 6	**158**	**8,948**	**56.5**	**18**	**94**	**2.4**
7	508	ATLANTA	56	4,083	72.9	0	0	0.0
7	509	AUGUSTA	69	3,533	52.1	0	0	0.0
7	521	BIRMINGHAM	25	1,937	77.5	0	0	0.0
7	679	TUSCALOOSA	67	4,900	73.1	0	0	0.0
7	619A4	TUSKEGEE	50	3,123	62.5	0	0	0.0
		VISN 7	**267**	**17,576**	**67.6**	**0**	**0**	**0.0**
8	573	GAINESVILLE	60	3,894	64.9	0	0	0.0
8	546	MIAMI	52	3,702	71.2	0	0	0.0
8	673	TAMPA	52	2,568	49.4	0	0	0.0
		VISN 8	**164**	**10,164**	**61.8**	**0**	**0**	**0.0**
10	538	CHILLICOTHE	70	3,829	54.7	0	0	0.0
10	539	CINCINNATI	114	4,999	43.9	0	0	0.0
10	541	CLEVELAND	166	9,868	59.5	10	21	2.1
10	757	COLUMBUS	27	1,030	38.2	0	0	0.0
10	552	DAYTON	107	4,471	41.8	0	0	0.0
10	541B2	YOUNGSTOWN	44	2,905	66.0	0	0	0.0
		VISN 10	**528**	**27,102**	**50.7**	**10**	**21**	**0.4**
11	506	ANN ARBOR HCS	53	3,865	72.9	0	0	0.0
11	515	BATTLE CREEK	70	3,722	53.2	34	58	1.7
11	553	DETROIT VAMC	94	3,005	32.0	1	2	2.0
11	610	NORTHERN INDIANA	81	5,468	67.5	1	7	7.0
		VISN 11	**298**	**16,060**	**56.4**	**36**	**67**	**2.7**
12	537	CHICAGO WEST SIDE	63	4,034	64.0	0	0	0.0

VISN	SITE CODE	SITE NAME/VISN	MHICM Visits (Stop Code 552 Visits) #Veterans	#Visits	MnVisits	Low Intensity CM Visits (Stop Code 564 Visits) #Veterans	#Visits	MnVisits
12	607	MADISON	48	6,420	133.8	0	0	0.0
12	695	MILWAUKEE	31	2,013	64.9	0	0	0.0
12	556	NORTH CHICAGO	117	12,277	104.9	0	0	0.0
12	676	TOMAH,WI	46	5,171	112.4	0	0	0.0
		VISN 12	**305**	**29,915**	**96.0**	**0**	**0**	**0.0**
15	657A7	ST.LOUIS,MO	52	2,736	52.6	0	0	0.0
15	677	TOPEKA	108	12,451	115.3	0	0	0.0
		VISN 15	**160**	**15,187**	**84.0**	**0**	**0**	**0.0**
16	520	GULF COAST	57	2,650	46.5	3	3	1.0
16	580	HOUSTON	62	2,720	43.9	0	0	0.0
16	598	LITTLE ROCK	48	3,492	72.8	42	268	6.4
16	629	NEW ORLEANS	57	1,996	35.0	0	0	0.0
		VISN 16	**224**	**10,858**	**49.5**	**45**	**271**	**1.8**
17	549	DALLAS	71	5,185	73.0	0	0	0.0
17	685	WACO	47	3,530	75.1	0	0	0.0
		VISN 17	**118**	**8,715**	**74.1**	**0**	**0**	**0.0**
18	501	ALBUQUERQUE	62	4,867	78.5	0	0	0.0
18	644	PHOENIX	80	2,416	30.2	0	0	0.0
		VISN 18	**142**	**7,283**	**54.4**	**0**	**0**	**0.0**
19	554	DENVER	74	3,697	50.0	0	0	0.0
19	575	GRAND JUNCTION	48	2,695	56.2	0	0	0.0
19	660	SALT LAKE CITY	54	2,518	46.6	4	4	1.0
19	666	SHERIDAN	17	643	37.8	0	0	0.0
19	567	SOUTHERN COLORADO	90	4,711	52.3	0	0	0.0
		VISN19	**283**	**14,264**	**48.6**	**4**	**4**	**0.2**
20	663A4	AMERICAN LAKE	49	2,435	49.7	1	1	1.0
20	531	BOISE	40	963	24.1	0	0	0.0
20	648	PORTLAND	75	4,581	61.1	8	20	2.5
20	663	SEATTLE	56	2,774	49.5	1	20	20.0
		VISN 20	**220**	**10,753**	**46.1**	**10**	**41**	**5.9**
21	640	PALO ALTO	45	1,838	40.8	0	0	0.0
21	662	SAN FRANCISCO	45	2,421	53.8	0	0	0.0
		VISN 21	**90**	**4,259**	**47.3**	**0**	**0**	**0.0**
22	691	GREATER LOS ANGELE	48	1021	21.3	0	0	0.0
22	664	SAN DIEGO	47	2379	50.6	0	0	0.0
		VISN 22	**95**	**3,400**	**35.9**	**0**	**0**	**0.0**
23	636A8	IOWA CITY,IA	42	1,683	40.1	0	0	0.0
23	636A7	KNOXVILLE	89	4,432	49.8	0	0	0.0
23	618	MINNEAPOLIS	68	3,201	47.1	1	3	3.0
23	636	OMAHA,NE	39	2,239	57.4	0	0	0.0
23	656	ST.CLOUD	38	1,470	38.7	3	18	6.0
		VISN 23	**276**	**13,025**	**46.6**	**4**	**21**	**1.8**
		Facility Sum	**4,577**	**264,722**	**57.8**	**186**	**966**	**5.2**
		VISN Mean	**229**	**13,236**	**56.2**	**9**	**48**	**1.3**
		Standard Deviation	**101.8**	**6839.8**	**14.9**	**15.0**	**86.1**	**2.1**
		Coefficient of Variation	**0.4**	**0.5**	**0.3**	**1.6**	**1.8**	**1.6**

* MHICM teams submitted Initial Data Forms and Follow-up monitoring data for these veterans to NEPEC.

Appendix F
Non-MHICM Case Management Services, FY 2004
(Non-MHICM Veterans at MHICM and Non-MHICM Sites~)

VISN	SITE CODE	SITE NAME	MHICM Visits (Stop Code 552) #Veterans	#Visits	MnVisits	General CM Visits (Stop Code 564) #Veterans	#Visits	MnVisits
1	402	TOGUS*	34	712	20.9	0	0	0.0
1	518	BEDFORD*	92	1,718	18.7	0	0	0.0
1	523A5	BROCKTON VAMC*	20	75	3.8	0	0	0.0
1	523GB	WORCESTER CBOC MA	3	3	1.0	0	0	0.0
1	689	WEST HAVEN*	1	1	1.0	0	0	0.0
		VISN 1	**150**	**2,509**	**16.7**	**0**	**0**	**0.0**
2	528	UPSTATE N.Y. HCS BUFFALO*	51	325	6.4	0	0	0.0
2	528A5	CANANDIAGUA DIVISION*	71	3,438	48.4	0	0	0.0
2	528A7	HCS UPSTATE NY V2 SYRACUSE*	21	160	7.6	0	0	0.0
2	528A8	HCS UPSTATE NY V2 ALBANY*	39	131	3.4	0	0	0.0
		VISN 2	**182**	**4,054**	**22.3**	**0**	**0**	**0.0**
3	526	BRONX#	200	1,561	7.8	0	0	0.0
3	561A4	LYONS*	13	234	18.0	2	3	1.5
3	561BY	NEWARK-SOC	6	9	1.5	40	691	17.3
3	620	MONTROSE VA HUDSON HCS NY*	16	197	12.3	73	477	6.5
3	620A4	CASTLE PNT VA HUDSON HCS NY	2	7	3.5	0	0	0.0
3	620GA	NEW CITY (ROCKLAND) CBOC	0	0	0.0	86	262	3.1
3	630GC	BROOKLYN CBOC	19	215	11.3	0	0	0.0
3	632	NORTHPORT*	40	465	11.6	2	61	30.5
		VISN 3	**296**	**2,688**	**9.1**	**203**	**1,494**	**7.4**
4	540	CLARKSBURG	14	15	1.1	0	0	0.0
4	542	COATESVILLE*	51	315	6.2	171	2,197	12.9
4	595	LEBANON	9	266	29.6	17	201	11.8
4	642	PHILADELPHIA (OLD)	25	659	26.4	0	0	0.0
4	646A5	PITTSBURGH-HIGHLAND DR*	13	222	17.1	0	0	0.0
4	693B4	ALLENTOWN-SOC	5	11	2.2	0	0	0.0
4	693	WILKES BARRE	43	282	6.6	0	0	0.0
		VISN 4	**160**	**1,770**	**11.1**	**188**	**2,398**	**12.8**
5	512	BALTIMORE*	37	918	24.8	0	0	0.0
5	512A5	PERRY POINT*	53	290	5.5	0	0	0.0
5	613	MARTINSBURG	12	112	9.3	0	0	0.0
5	688	WASHINGTON DC*	129	1,912	14.8	0	0	0.0
		VISN 5	**231**	**3,232**	**14.0**	**0**	**0**	**0.0**
6	558	DURHAM	0	0	0.0	33	362	11.0
6	565	FAYETTEVILLE NC*	12	99	8.3	0	0	0.0
6	590	HAMPTON*	40	317	7.9	0	0	0.0
6	637	ASHEVILLE-OTEEN	0	0	0.0	57	122	2.1
6	658	SALEM*	21	200	9.5	202	422	2.1
6	659	SALISBURY*	12	114	9.5	110	981	8.9
6	659GA	CHARLOTTE CBOC	0	0	0.0	138	544	3.9
		VISN 6	**85**	**730**	**8.6**	**540**	**2,431**	**4.5**
7	508	ATLANTA*	20	30	1.5	0	0	0.0
7	509A0	LENWOOD	26	108	4.2	0	0	0.0
7	521	BIRMINGHAM^	10	42	4.2	0	0	0.0
7	534	CHARLESTON	27	1,179	43.7	0	0	0.0
7	544	COLUMBIA SC^	76	2,108	27.7	0	0	0.0
7	557	DUBLIN	1	5	5.0	0	0	0.0
7	619	MONTGOMERY	5	5	1.0	0	0	0.0
7	619A4	TUSKEGEE*	50	747	14.9	0	0	0.0
7	679	TUSCALOOSA*	58	413	7.1	0	0	0.0
		VISN 7	**273**	**4,637**	**17.0**	**0**	**0**	**0.0**
8	546	MIAMI*	35	133	3.8	0	0	0.0
8	548	W PALM BEACH^	7	182	26.0	2	2	1.0
8	573	N FL/S GA HCS*	23	117	5.1	0	0	0.0
8	672	SAN JUAN PR	0	0	0.0	43	50	1.2

Appendix F
Non-MHICM Case Management Services, FY 2004
(Non-MHICM Veterans at MHICM and Non-MHICM Sites~)

VISN	SITE CODE	SITE NAME	MHICM Visits (Stop Code 552) #Veterans	#Visits	MnVisits	General CM Visits (Stop Code 564) #Veterans	#Visits	MnVisits
8	673	TAMPA*	23	229	10.0	0	0	0.0
8	673BY	ORLANDO-SOC	8	31	3.9	0	0	0.0
		VISN 8	**96**	**692**	**7.2**	**45**	**52**	**1.2**
9	621	MOUNTAIN HOME*	188	2,100	11.2	0	0	0.0
		VISN 9	**188**	**2,100**	**11.2**	**0**	**0**	**0.0**
10	538	CHILLICOTHE*	12	159	13.3	15	402	26.8
10	539	CINCINNATI*	52	416	8.0	0	0	0.0
10	541A0	CLEVELAND-BRECKSVILLE*	42	578	13.8	12	30	2.5
10	541GB	LORAIN CBOC^	4	10	2.5	0	0	0.0
10	541GD	MANSFIELD CBOC^	22	763	34.7	48	850	17.7
10	541GF	PINESVILLE CBOC PH	4	6	1.5	0	0	0.0
10	541GI	WARREN CBOC CLEVELAND OH^	15	128	8.5	0	0	0.0
10	552	DAYTON*	16	115	7.2	0	0	0.0
10	552GA	MIDDLETOWN CBOC	1	2	2.0	0	0	0.0
10	552GB	LIMA CBOC OH	3	5	1.7	0	0	0.0
10	552GC	RICHMOND CBOC IN	5	47	9.4	0	0	0.0
10	552GD	SPRINGFIELD CBOC OH	8	32	4.0	0	0	0.0
10	757	COLUMBUS-IOC	9	65	7.2	0	0	0.0
10	757GB	GROVE CITY CBOC OH	20	171	8.6	0	0	0.0
		VISN 10	**213**	**2,497**	**11.7**	**75**	**1,282**	**17.1**
11	506	ANN ARBOR HCS*	4	253	63.3	0	0	0.0
11	515	BATTLE CREEK*	47	382	8.1	78	259	3.3
11	550	VA ILLIANA HCS DANVILLE IL	33	1,190	36.1	31	2,514	81.1
11	550BY	PEORIA-SOC	0	0	0.0	1	3	3.0
11	553	DETROIT VAMC*	9	91	10.1	0	0	0.0
11	610	NORTHERN INDIANA HCS*	15	419	27.9	10	324	32.4
11	610A4	NORTHERN IN HCS	0	0	0.0	46	1,445	31.4
		VISN 11	**108**	**2,335**	**21.6**	**166**	**4,545**	**27.4**
12	537	VA CHICAGO HCS*	31	571	18.4	0	0	0.0
12	556	NORTH CHICAGO*	33	390	11.8	0	0	0.0
12	556GD	KENOSHA CBOC WI	2	2	1.0	0	0	0.0
12	578	HINES	3	5	1.7	104	4,655	44.8
12	607	MADISON*	10	128	12.8	0	0	0.0
12	676	TOMAH*	17	272	16.0	0	0	0.0
12	695	MILWAUKEE*	3	7	2.3	0	0	0.0
		VISN 12	**99**	**1,375**	**13.9**	**0**	**0**	**0.0**
15	589A5	COLMERY-ONEIL VAMC HCS KS*	53	1,464	27.6	26	87	3.4
15	657A0	ST LOUIS-Jeff Bks.	36	200	5.6	0	0	0.0
		VISN 15	**89**	**1,664**	**18.7**	**26**	**87**	**3.3**
16	520	GULF COAST HCS	0	0	0.0	4	4	1.0
16	520A0	GULFPORT*	32	217	6.8	7	9	1.3
16	580	HOUSTON*	16	223	13.9	0	0	0.0
16	586	JACKSON	0	0	0.0	72	267	3.7
16	598A0	N. LITTLE ROCK*	43	145	3.4	641	4,825	7.5
16	629	NEW ORLEANS*	5	114	22.8	0	0	0.0
		VISN 16	**96**	**699**	**7.3**	**724**	**5,105**	**7.1**
17	549	DALLAS*	23	160	7.0	0	0	0.0
17	671	SAN ANTONIO^	27	1,582	58.6	0	0	0.0
17	674A4	WACO*	52	771	14.8	0	0	0.0
		VISN 17	**102**	**2,513**	**25**	**0**	**0**	**0.0**
18	501	NEW MEXICO HCS*	16	25	1.6	0	0	0.0
18	644	PHOENIX*	47	481	10.2	55	294	5.4
		VISN 18	**63**	**506**	**8.0**	**55**	**294**	**5.3**
19	442	CHEYENNE	41	689	16.8	0	0	0.0
19	554	DENVER*	33	779	23.6	8	55	6.9

Appendix F
Non-MHICM Case Management Services, FY 2004
(Non-MHICM Veterans at MHICM and Non-MHICM Sites~)

VISN	SITE CODE	SITE NAME	MHICM Visits (Stop Code 552) #Veterans	MHICM Visits (Stop Code 552) #Visits	MHICM Visits (Stop Code 552) MnVisits	General CM Visits (Stop Code 564) #Veterans	General CM Visits (Stop Code 564) #Visits	General CM Visits (Stop Code 564) MnVisits
19	554GE	COLORADO SPGS CBOC CO	11	113	10.3	0	0	0.0
19	554GG	LA JUNTA CBOC CO	6	43	7.2	0	0	0.0
19	575	GRAND JUNCTION*	18	164	9.1	0	0	0.0
19	660	SALT LAKE CITY HTHCARE*	26	246	9.5	4	6	1.5
19	666	SHERIDAN^	19	89	4.7	0	0	0.0
		VISN 19	**154**	**2,123**	**13.8**	**12**	**61**	**5.1**
20	531	BOISE*	11	19	1.7	0	0	0.0
20	648	PORTLAND*	39	717	18.4	15	245	16.3
20	653	ROSEBURG	65	765	11.8	0	0	0.0
20	653BY	EUGENE-SOC	7	78	11.1	0	0	0.0
20	663	PUGET SOUND HCS*	32	107	3.3	1	2	2.0
20	663A4	AMERICAN LAKE*	9	182	20.2	0	0	0.0
20	668	SPOKANE WA#	0	0	0.0	98	2,355	24.0
		VISN 20	**163**	**1,868**	**11.5**	**114**	**2,602**	**22.8**
21	640A0	PALO ALTO-MENLO PK	9	15	1.7	0	0	0.0
21	640BY	SAN JOSE	13	19	1.5	0	0	0.0
		VISN 21	**22**	**34**	**1.5**	**0**	**0**	**0.0**
22	593	VA SOUTHERN NEVADA HCS	0	0	0.0	66	639	9.7
22	600	VA LONG BEACH HCS CA	24	564	23.5	1	1	1.0
22	600GC	LONG BEACH CBOC	0	0	0.0	114	130	1.1
22	664	VA SAN DIEGO HCS CA^	32	87	2.7	0	0	0.0
22	691	GREATER LA HCS*	43	103	2.4	1	1	1.0
		VISN 22	**99**	**754**	**7.6**	**182**	**771**	**4.2**
23	437	FARGO	0	0	0.0	117	736	6.3
23	438	SIOUX FALLS	0	0	0.0	113	697	6.2
23	618	MINNEAPOLIS*	5	21	4.2	0	0	0.0
23	636	VA NEB-WESTERN IA HCS*	5	25	5.0	0	0	0.0
23	636A6	VA CPHN DES MOINES IA*	7	132	18.9	0	0	0.0
23	636A7	VA CPHN KNOXVILLE IA*	26	271	10.4	0	0	0.0
23	636A8	VA CPHN IOWA CITY IA*	11	153	13.9	0	0	0.0
23	656	ST CLOUD*	7	107	15.3	21	327	15.6
		VISN 23	**61**	**709**	**11.6**	**251**	**1,760**	**7.0**
		ALL SUM/MEAN	**2,930**	**39,489**	**13.5**	**2,581**	**22,882**	**8.9**
		VISN Mean	**140**	**1,880**	**12.8**	**123**	**1,090**	**6.0**
		Standard Deviation	**69.8**	**1168.6**	**5.6**	**185.6**	**1510.0**	**7.9**
		Coefficient of Variation	**0.5**	**0.6**	**0.4**	**1.5**	**1.4**	**1.3**

~ Non-MHICM veterans were identified through VHA Automated databases in Austin, Texas.
* MHICM team operational during in FY 2004. # MHICM team not operational in FY 2004.
^ MHICM team in development during FY 2004.

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Appendix G
MHICM Complex VERA Veterans, FY 2004

This table presents numbers and proportions of veterans added to the Complex Care VERA reimbursement class due to participation in MHICM. To attain this reimbursement status, veterans must be registered in MHICM and receive 41 or more MHICM clinic stops (visits) during the fiscal year. These criteria are monitored by VHA's Allocation Resource Center (ARC) and the Northeast Program Evaluation Center (NEPEC). For FY 2004, VERA reimbursement for a veteran in the VERA MHICM Complex Care Patient Class was set at $35,957 per year.

VISN	Site Code	Site Name	MHICM Veterans FY 2004 #	MHICM Complex^ VERA Veterans #	MHICM Complex VERA Veterans %	CMI Complex~ VERA Veterans #	CMI Complex VERA Veterans %	Total Complex VERA Veterans
1	518	Bedford	130	90	69.2%	29	22.3%	91.5%
1	523A5	Brockton	79	34	43.0%	38	48.1%	91.1%
1	402	Togus	27	19	70.4%	3	11.1%	81.5%
1	689	West Haven	62	46	74.2%	10	16.1%	90.3%
		VISN 1	**298**	**189**	**63.4%**	**80**	**26.8%**	**90.3%**
2	528A8	Albany	49	30	61.2%	11	22.4%	83.7%
2	528	Buffalo	83	39	47.0%	22	26.5%	73.5%
2	528A5	Canandaigua	101	66	65.3%	27	26.7%	92.1%
2	528A7	Syracuse	53	13	24.5%	23	43.4%	67.9%
		VISN 2	**286**	**148**	**51.7%**	**83**	**29.0%**	**80.8%**
3	630A4	Brooklyn	58	16	27.6%	29	50.0%	77.6%
3	620	Montrose	102	75	73.5%	20	19.6%	93.1%
3	561A4	New Jersey	89	38	42.7%	35	39.3%	82.0%
3	632	Northport	103	56	54.4%	39	37.9%	92.2%
		VISN 3	**352**	**185**	**52.6%**	**123**	**34.9%**	**87.5%**
4	542	Coatesville	101	49	48.5%	35	34.7%	83.2%
4	646A5	Pittsburgh	136	45	33.1%	73	53.7%	86.8%
		VISN 4	**237**	**94**	**39.7%**	**108**	**45.6%**	**85.2%**
5	512	Martinsburg	33	9	27.3%	11	33.3%	60.6%
5	512A5	Perry Point	91	41	45.1%	44	48.4%	93.4%
		VISN 5	**124**	**50**	**40.3%**	**55**	**44.4%**	**84.7%**
6	590	Fayetteville, NC	27	23	85.2%	1	3.7%	88.9%
6	658	Hampton	59	35	59.3%	16	27.1%	86.4%
		Salem	44	17	38.6%	17	38.6%	77.3%
6	659	Salisbury	38	22	57.9%	11	28.9%	86.8%
		VISN 6	**168**	**97**	**57.7%**	**45**	**26.8%**	**84.5%**
7	508	Atlanta	61	45	73.8%	10	16.4%	90.2%
7	509	Augusta	71	40	56.3%	26	36.6%	93.0%
		Birmingham	25	18	72.0%	6	24.0%	96.0%
7	679	Tuscaloosa	69	49	71.0%	18	26.1%	97.1%
7	619A4	Tuskegee	52	37	71.2%	10	19.2%	90.4%
		VISN 7	**278**	**189**	**68.0%**	**70**	**25.2%**	**93.2%**
8	573	Gainesville	62	44	71.0%	15	24.2%	95.2%
		Miami	53	43	81.1%	7	13.2%	94.3%
8	546	Tampa	52	27	51.9%	8	15.4%	67.3%
		VISN 8	**167**	**114**	**68.3%**	**30**	**18.0%**	**86.2%**
10	538	Chillicothe	73	51	69.9%	5	6.8%	76.7%
10	539	Cincinnati	116	91	78.4%	10	8.6%	87.1%
10	541	Cleveland	169	99	58.6%	34	20.1%	78.7%
10	757	Columbus	27	9	33.3%	11	40.7%	74.1%
10	552	Dayton	110	69	62.7%	12	10.9%	73.6%
10	541B2	Youngstown	45	25	55.6%	9	20.0%	75.6%
		VISN 10	**540**	**344**	**63.7%**	**81**	**15.0%**	**78.7%**
11	506	Ann Arbor	54	25	46.3%	19	35.2%	81.5%
11	515	Battle Creek	72	50	69.4%	13	18.1%	87.5%
11	553	Detroit	94	26	27.7%	54	57.4%	85.1%
11	610	Northern Indiana	82	51	62.2%	23	28.0%	90.2%
		VISN 11	**302**	**152**	**50.3%**	**109**	**36.1%**	**86.4%**

VISN	Site Code	Site Name	MHICM Veterans FY 2004 #	MHICM Complex^ VERA Veterans #	MHICM Complex VERA Veterans %	CMI Complex~ VERA Veterans #	CMI Complex VERA Veterans %	Total Complex VERA Veterans
12	537	Chicago West Side	70	44	62.9%	17	24.3%	87.1%
12	607	Madison	49	39	79.6%	3	6.1%	85.7%
12	695	Milwaukee	33	24	72.7%	8	24.2%	97.0%
12	556	North Chicago	118	90	76.3%	19	16.1%	92.4%
12	676	Tomah	48	30	62.5%	6	12.5%	75.0%
		VISN 12	**318**	**227**	**71.4%**	**53**	**16.7%**	**88.1%**
15	657A0	ST. Louis	54	28	51.9%	12	22.2%	74.1%
15	589A5	Topeka	112	79	70.5%	23	20.5%	91.1%
		VISN 15	**166**	**107**	**64.5%**	**35**	**21.1%**	**85.5%**
16	520	Gulf Coast	61	18	29.5%	36	59.0%	88.5%
16	580	Houston	64	48	75.0%	10	15.6%	90.6%
16	598	Little Rock	49	37	75.5%	9	18.4%	93.9%
16	629	New Orleans	58	25	43.1%	19	32.8%	75.9%
		VISN 16	**232**	**128**	**55.2%**	**74**	**31.9%**	**87.1%**
17	549	Dallas	73	56	76.7%	8	11.0%	87.7%
17	685	Waco	65	36	55.4%	18	27.7%	83.1%
		VISN 17	**138**	**92**	**66.7%**	**26**	**18.8%**	**85.5%**
18	501	Albuquerque	64	43	67.2%	13	20.3%	87.5%
18	644	Phoenix	84	25	29.8%	22	26.2%	56.0%
		VISN 18	**148**	**68**	**45.9%**	**35**	**23.6%**	**69.6%**
19	554	Denver	74	48	64.9%	22	29.7%	94.6%
19	575	Grand Junction	48	29	60.4%	11	22.9%	83.3%
19	660	Salt Lake City	56	27	48.2%	20	35.7%	83.9%
19	666	Sheridan	18	6	33.3%	9	50.0%	83.3%
19	567	Southern Colorado	97	62	63.9%	17	17.5%	81.4%
		VISN 19	**293**	**172**	**58.7%**	**79**	**27.0%**	**85.7%**
20	663A4	American Lake	51	36	70.6%	15	29.4%	100.0%
20	531	Boise	42	2	4.8%	23	54.8%	59.5%
20	648	Portland	78	46	59.0%	24	30.8%	89.7%
20	663	Seattle	58	24	41.4%	23	39.7%	81.0%
		VISN 20	**229**	**108**	**47.2%**	**85**	**37.1%**	**84.3%**
21	640	Palo Alto	45	27	60.0%	13	28.9%	88.9%
21	662	San Francisco	48	33	68.8%	10	20.8%	89.6%
		VISN 21	**93**	**60**	**64.5%**	**23**	**24.7%**	**89.2%**
22	691	Greater Los Angeles	51	4	7.8%	37	72.5%	80.4%
		San Diego	48	24	50.0%	14	29.2%	79.2%
		VISN 22	**99**	**28**	**28.3%**	**51**	**51.5%**	**79.8%**
23	636A8	Iowa City	50	23	46.0%	13	26.0%	72.0%
23	636A7	Knoxville	90	62	68.9%	16	17.8%	86.7%
23	618	Minneapolis	72	40	55.6%	24	33.3%	88.9%
23	636	Omaha	42	24	57.1%	8	19.0%	76.2%
23	656	St. Cloud	39	14	35.9%	20	51.3%	87.2%
		VISN 23	**293**	**163**	**55.6%**	**81**	**27.6%**	**83.3%**
		ALL SUM/MEAN	**4,761**	**2,715**	**57.0%**	**1,326**	**27.9%**	**84.9%**
		VISN Mean	**227**	**129**	**55.7%**	**63**	**29.1%**	**84.8%**
		Standard Deviation	**103.7**	**70.3**	**11.0%**	**28.3**	**9.7%**	**4.8%**
		Coefficient of Variation	**0.5**	**0.5**	**0.2**	**0.4**	**0.3**	**0.1**

^MHICM veterans with 41 or more MHICM visits (Clinic Stop 552) during FY 2004.

~MHICM veterans assigned to Chronic Mental Illness (CMI) Patient Class based on diagnosis and prior service use.

Source: Allocation Resource Center; NEPEC Monitoring files.

Appendix H
MHICM Program Monitor Trends, FY 1997-2004

Team Structure	1997	2001	2002	2003	2004	% change 2004-1997
Teams*	40	55	72	74	78	95%
Clients^	2,021	3,189	3,566	4,108	4,761	136%
Expenditures	$12.7M	$18.4M	$20.0M	$26.7M	$33.8M	166%
Assigned FTEE	246	289	315	393	453	84%
Filled FTEE	221	251	283	356	415	88%
% Filled	90%	87%	90%	91%	92%	2%
Teams with 4.0 Clinical FTE	53%	46%	46%	54%	51%	-3%
Staff detailed away PT (sites)	8%	25%	21%	30%	16%	100%
Cost/Client	$6,049	$5,777	$5,607	$6,509	$7,105	17%
Client/Staff ratio	12.3	13.2	12.9	12.3	12.5	2%

Client Characteristics (Entry)	1997	2001	2002	2003	2004	% change 2004-1997
Age	49.2	49.8	49.9	50.2	50.4	2%
Minority race / ethnicity	29.1%	32.1%	32.4%	33.9%	33.2%	14%
Mean hospital days in year pre	135.4	99.9	92.3	87.9	79.6	-41%
30+ Hospital days in year pre	91.3%	78.6%	76.9%	76.6%	75.1%	-18%
2+ yrs Hospitalized in lifetime	57.9%	56.9%	48.2%	46.8%	43.6%	-25%
Psychotic diagnosis	87.0%	90.7%	90.7%	90.2%	88.9%	2%
Substance use diagnosis	25%	20%	20%	20.8%	20.9%	-16%
Paid employment (3yrs pre)	12.5%	11.3	11.5%	11.4%	12.5%	0%
Public support income	90.6%	94.1%	94.8%	94.2%	94.1%	4%

MHICM Services	1997	2001	2002	2003	2004	% change 2004-1997
Contacted weekly	85%	81%	87%	87%	88%	4%
Contacts/week	1.6	1.3	1.4	1.4	1.3	-19%
60% + contacts in community	78%	84%	88%	89%	89%	14%
Discharged	16%	14%	13%	14%	16%	0%
Client-rated Alliance	31.4	39.2	39.4	39.6	39.8	27%
Team ACT Fidelity Score	4.0	3.8	4.0	4.0	4.0	0%

Client Outcome (Follow-up)	1997	2001	2002	2003	2004	% change 2004-1997
BPRS Observed symptoms	-7%	-10%	-10%	-13%	-14%	100%
BSI Reported symptoms	-6%	-10%	-11%	-13%	-13%	117%
Instrumental Functioning	1%	3%	2%	3%	3%	167%
Quality of Life reported	8%	10%	10%	10%	10%	25%
Housing Independence^		14%	13%	14%	13%	-6%
Satisfaction w/ MHICM (1-5)	3.7	3.7	3.7	3.7	3.7	1%
Change Inpatient days (6mos.)	-50	-42	-35	-33	-30	-39%
% Change Inpatient days (6mos.)	-64%	-73%	-72%	-72%	-71%	11%

* 71 of 78 teams in operation had sufficient data to be included in the FY 2004 report.
Remaining values for this table reflect those sites.

^ Introduced in FY 1999 Report.

End of MHICM 8th National Performance Monitoring Report - FY 2004